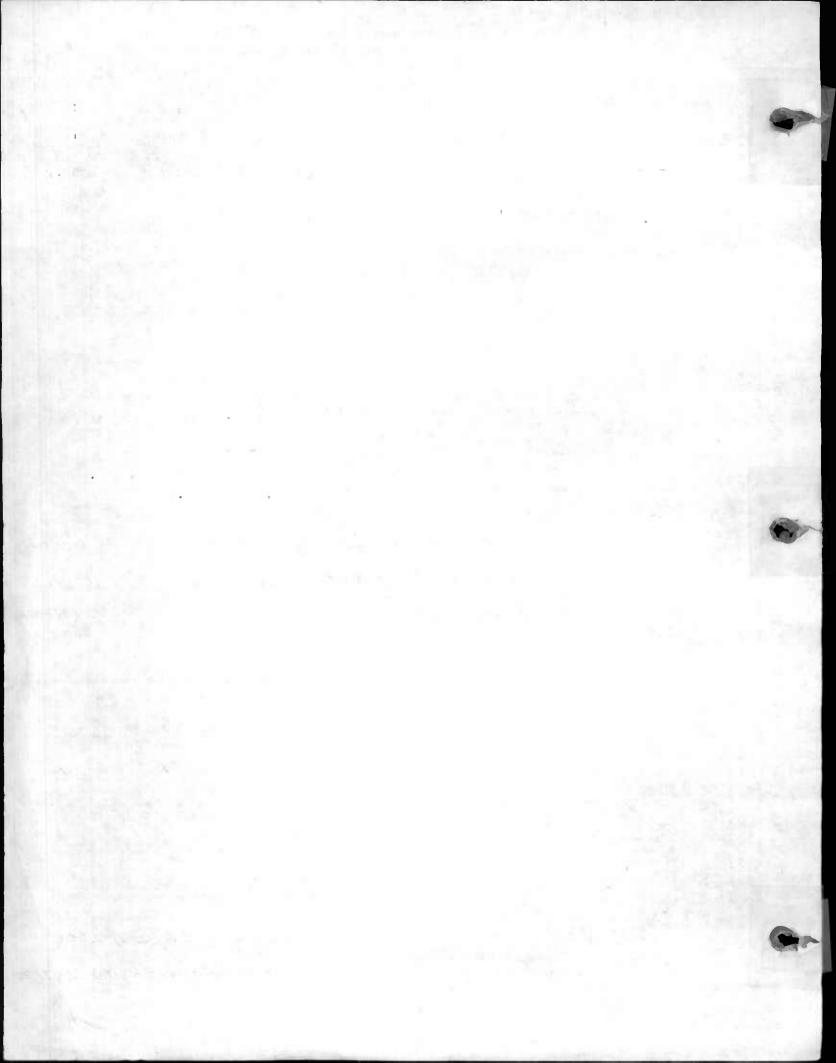
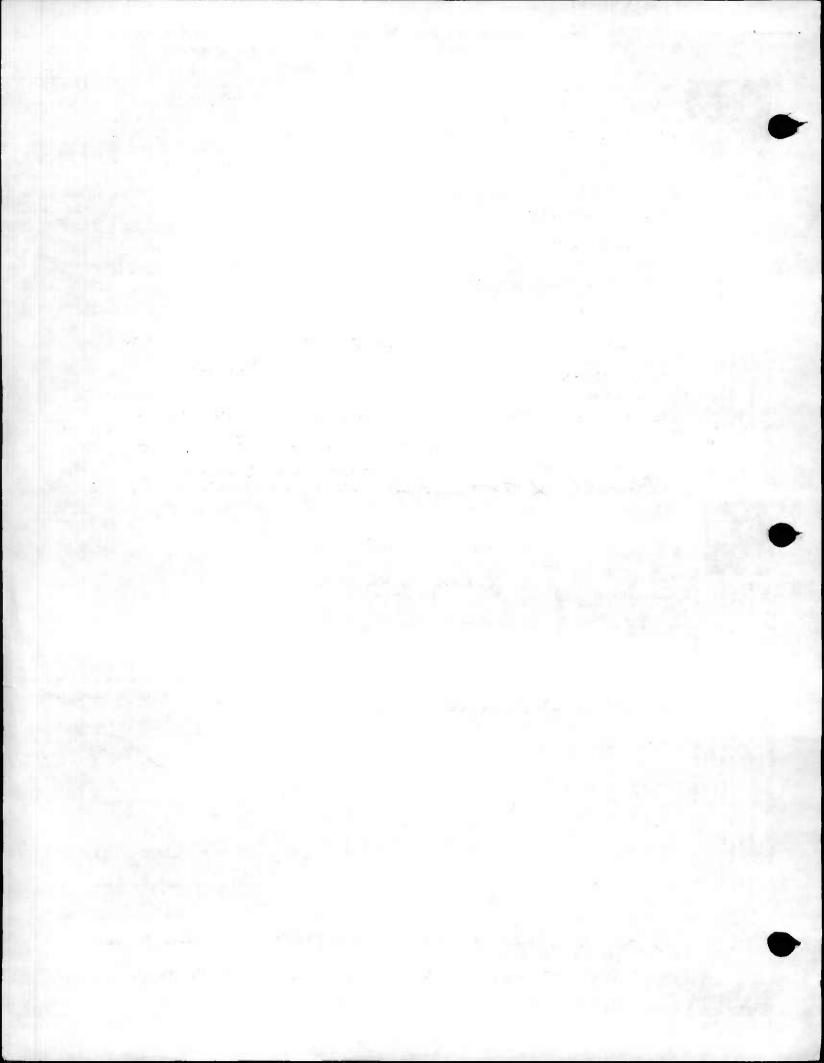
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	Decedent's Nama (First, Middle, La	est)	0	ertificate	UI DEAIII	2. Dete of D		3. Tima of Deeth
ysician	YOLANDA	NORRINE	REID			JUNE	23, 2000	7:47 PM
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Her	DOCTORS COMM	HINITY HOSE	DITAI		LANIL	Λ Μ	DDINCE	CEODCEIC
			e (In yrs. lest birthda	(v) If Under 1 Y	LANH eer If Under 24 Hr	Al ^V I s. 8. Dete of B	PRINCE	GEORGE S
		1□M 2⊠F	74 Yrs.	Months D	eys Hours Mir	1. (Month, D	14 1926	9. Birthplace (State or Foreig Country) Wash., D
	10a. Stete 10b. County		10c. City, Town or	Location				10d. Inside City Limits
		George's		Landove				1 🕅 Yes 2 🗆 No
	10e. Street and Number	deorge s		10f. Zip Co			10g. Citizen of W	fhat Country?
	Section of the control of the contro		#203	101. 210 00				
	5648 Whitfi	eld Chapel		2 Mar Decedent	20706	Casait. Van an h		d States
	11. Merital Stetus	12. Was Decedent Armed Forces?	EVER III U.S.	If Yes, specify	of Hispanic Origin? (Cuben, Mexican, Pue	rto Rican, etc.)	Bleck	k, White, etc.
	1 Never Merried 2 Merried 3 Widowed 4 Divorced	1 Yes 2 If Yes, Give Yaar or Dates:	No	1 ☐ Yes 2X☐	No Specify:		Specify	Black
	15. Decedent's E	ducation	16a. De	pedant's Usuel O	ocupation	orkina	16b. Kind of Bu	siness/Industry
1	(Specify only highest gri	Collage (1-4or	5+)	DO NOT use r	one during most of we etired)	urking		
	12th			Clerk	<	E-F	Gov	ernment
	17. Fether's Neme (First, Middle, Last)			18. Mother's Ne	eme (First, Middle	e, Maiden Sumem	9)
	John Reid				M	arion Wa	lter	
	19a. Informent's Neme/Raletionship	(Type, Print)	19b. Ma	illing Address (Si	reet and Number or F			Steta, Zip Code)
	Cassandra Thompso							
	20e. Method of Disposition		20b. Pleca of Dis	position (Nema	of	Dete	·	City or Town, State
	1 Burial 2 □ Cremetion 3 □		Dloscant	Grove (Cemetery	6_20_00	McLea	n VA
	4 Donetion 5 Other (Special		-1		11		1.	-
	21. Signeture of Filmerel Service Lice	need 1		22. Name end A	ddress of Fecility	Capitol	Mortuary	, Inc.
	- arry	was	1	425 Mary	land Ave.	. NE Wa	sh. DC	20002
	23a. Pert1. Enter the disease, or com shock, or heart tailure. List only	plicetions thet cause	the death. Do not e	enter the mode of	dying, such as cardia	ac or respiretory	errest,	Approximete
H	SHOCK, OF HEART CHILDRED LIST OFFIN							Intervel Batwean Onset and Death
	Immediate Ceuse (Finel	METI	ASTATI	c. (UNG C	ANICE	0	3 MONTH
	disease or condition rasulting in death)	θ.			v,v0 C	111000	-	3 110/1/14
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		b. CHRO			TIVE L	UNG D	15643 E	10 YRS
	Sequentially list conditions, if eny, leading to immediata cause. Entar Undarlying Cause (Disease or injury that Initiated events	DALE	Oue to (or es e cons					1
	Cause (Disease or injury	C						< /WEE
	resulting in death) Last		Due to (or es e cons	equance of):				
1		d						
		<u> </u>						
	Part II. Other significant conditions of	contributing to death b	ut not rasulting in the	undarlying caus	e given in Pert I.	23b. Die	d tobacco uae con	tribute to the cause of death
						1/2	KYes 2□ No	3 Probably 4 Unknow
							s en eutopsy	24b. Wera eutopsy findings evailable prior to
						per	formed?	completion of cause of daeth?
ŀ						1L	Yas 2 No	1 Yes 2 No
	25. Was case referred to medical examinar?	Hospitel:				aath (Check only	ona)	-
	1 Yes 2 No	1 Z Nopatie				-	sidenca 6 Othe	
	27. Manner of Deeth 1 Pending	28e. Dete of Inju (Month, Da	y Year) 28b. Time	of 28c.	Injury at Work?	28d. Dascribe	how injury occurr	ed
	2 ☐ Accident Investigation	n		М	1 Yes 2 No			
	3 Suicide 6 Could not be determined		ury - At home, ferm,	street, fectory, of	fice	281. Location	(Street and Number	er or Rurel Route Number,
ĺ		building, at	c. (Specify			Only or 7	Swii, Ciuley	
	(Check only 2 Medical Exam	nysician: To the best	exeminetion end/or	ath occurred at the Investigation, in	ne time, date end place my opinion, deeth occ	ce, end due to the	e ceuse(s) end ma	nnar as stated. and dua to tha cause(s)
	one)	and menner st	eted.	00-11			0015	
	29b. Signeture end title of certifier	1001			cense number			(Month, Dey, Year)
	Se. Au	Janes V	The Cal	(/)	00155	28	06/2	6/2000
	, , ,							9/ 2000
	30. Name and address of person who	completed cause of d	eeth (Item 23e) (Tvp	e, Print)				6/2000
	30. Name and address of person who	completed cause of d	eeth (Item 23e) (Typ	e, Print)	ERRY ST	Mr. K	PAINIE	8 MD 2071
	30. Name and address of person who S.C.ARYA! 31. Date filed (Month, Day, Year)	VGAT, M	eeth (Item 23e) (Typ 1 3 3 er's Signature	e, Print) 308 Pe	ERRY ST	, 77 . K	PAINIER	R, MD 2071



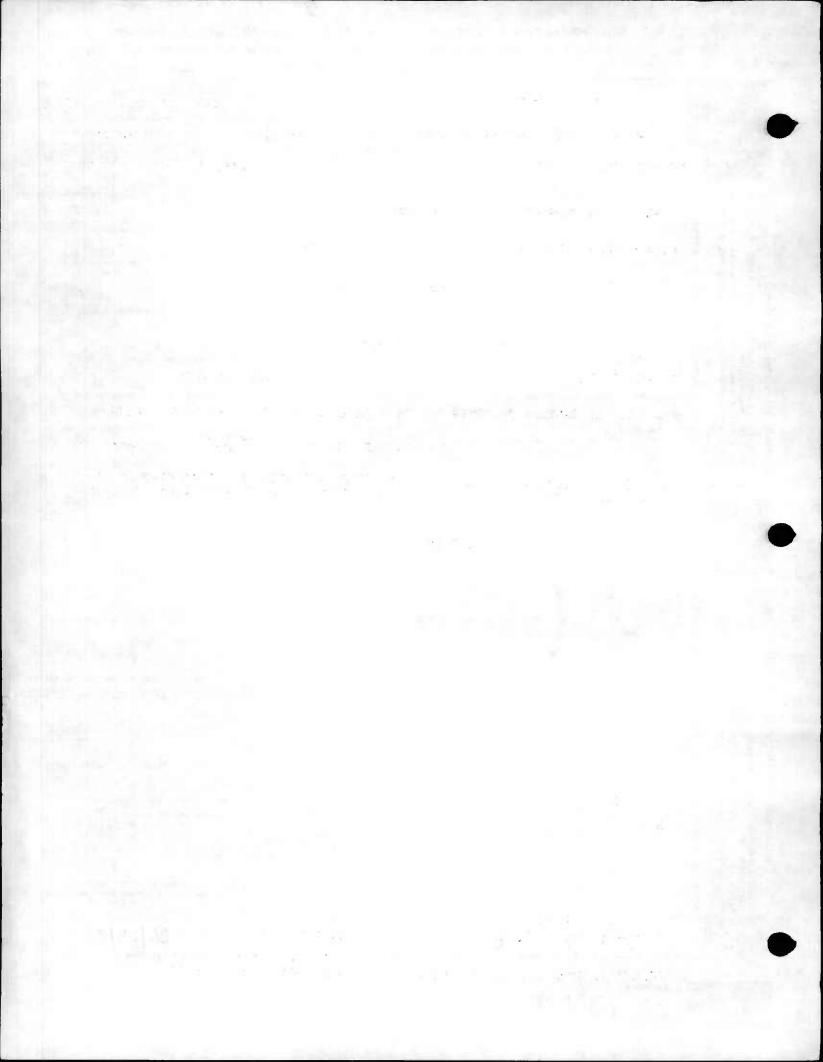
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 18, 2000 **Physician** LEO DAVID RHODE 10:30 am /Medical 4c. County of Death 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner HEBREW HOME OF GREATER WASHINGTON ROCKVILLE MONTGOMERY If Under 24 Hrs. Hours | Min. If Under 1 Year | Months | Deys 9. Birthplace (State or Foreign MASS. 8. Date of Birth Month Dev. Year) june13, 1915 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 6. Sex 1□ M 2□ F **Funeral** 85 Yrs 112-10-0228 Director Usuel Residence of Decedent death with the Marylend permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylen Department of Health end Mental Hygiene.
Important: If item 27 is merked other than "natural", or items 23s or 28s-f show any portant: or other traumatic event, the Westen Examples and page. 10a State 10c. City, Town or Location 10d. Inside City Limits 10b. County ¥FIYes 2□No Director MD. MONTGOMERY ROCKVILLE 10g. Citizen of What Country? 10f Zio Code 10e Street and Number 6111 MONTROSE RD 20852 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Black, White, etc. 11. Marital Status 1 Never Married Married 1 ☐ Yes 2 No Specify: WHITE 3altimore, Maryland 21215-0020 Specify: P 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BAKERY CLERK BAKERY 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be LENA CHAZEN MORRIS ROADE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) ROSE D. RHODE 6111 MONTROSE RD. ROCKVILLE MD. 20852 WIFE 20b. Place of Disposition (Name of cametery, cremetory or other place) Date 20c. Location - City or Town, Stete 20a. Method of Disposition 21, ALEXANDRIA, VA. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MT. COMFORT CREMATORY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses DANZANSKY-MEORIAL CHAPELS INC. 1170 ROCKVILE PIKE ROCKVILLE, MD. 20852 23a. Part1. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Cause (Final Infaire tion m yocardial disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Due to (dres e consequence of): Coronay attending physician and for usa as the bunel-transit The law requires that the death certificeta be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initieled events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medicai Due to (or es e consequence of): Part II. Other significant conditions confributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? been signed by the should be datached 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Althermens Disease à 24b. Were autopsy findings eveileble prior to Completed 24e. Was en autopsy completion of cause of death? s certificate has b 1 ☐ Yes 2 ☑ No 1 Yes 2 No Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this To the Hospital or Attending Phywithin 24 hours after death.

To the Funeral Director: After this complately filled in by the funeral of 28e. Date of Injury (Month, Dey Yeer) 27. Manner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Certification: 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Sulcide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) end manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, end due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00055258 , M.D. June 18, 2000 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Rockville Maryland 20852 31. Date filed (Month, Day, Year) He frew Home 6121 Montrose Road 32. Registrer's Signeture State JUN 2 6 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene

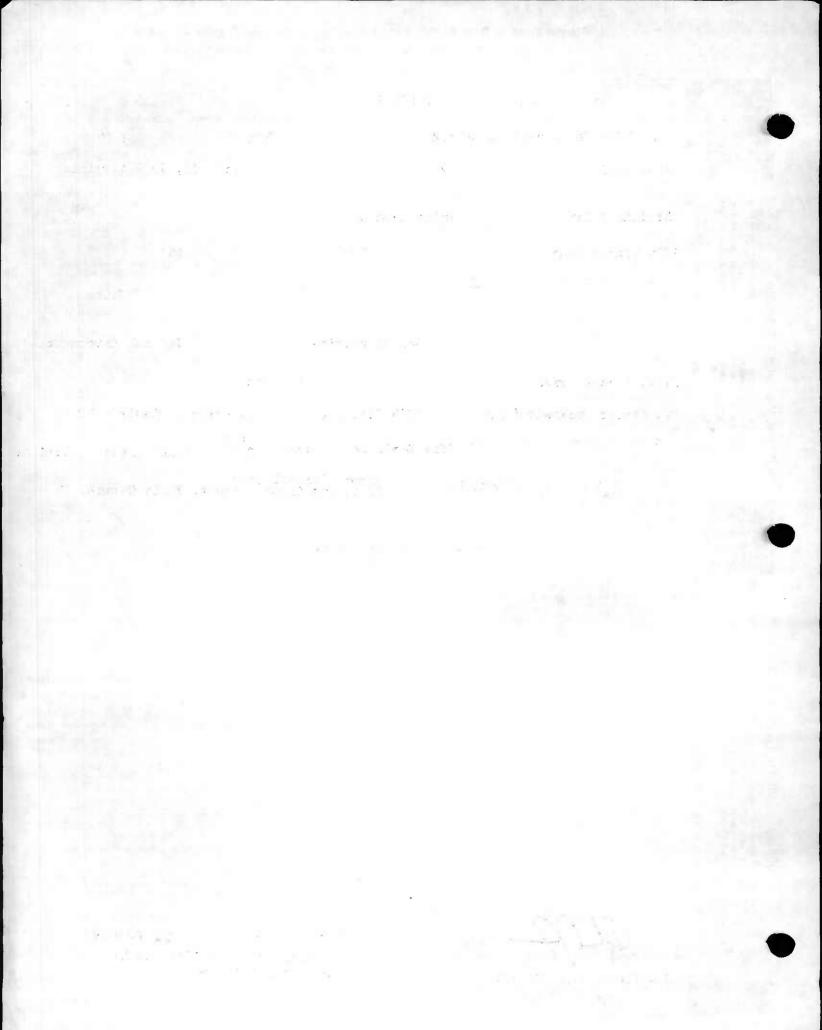
Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Year PHILIP MAURICE RISIK JUNE 27 2000 8:50 PM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NATIONAL NAVAL MEDICAL CENTER BETHESDA MONTGOMERY If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) JAN 8, 19 Birthplace (State or Foreign Country)
 NEW YORK If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F **Funeral** Days 1914 084-03-5948 86 Yrs. Director Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inaide City Limits rail, or items 23a or 28a-f show Examiner must be notified at 1X Yes 2 □ No MD MONTGOMERY POTOMAC Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? permit. Peges 1 and 2 should be filed within 72 hours effer death with t Department of Health and Mentel Hygiene.
Important: if item 27 is marked other than "natural", or items 23s or any loury or other traumatic event, the Medical Eventing must be an ange. 10224 WINDSOR VIEW DR. 20854 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: WW] Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian. Black, White, etc. 1 Never Married 2 N Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: WWII Specify. þ 3 Widowed 4 Divorced WHITE Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **JUDGE** LAW 5+ 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CELIA MERKEN 10 ISIDORE RISIK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9412 EAGLE RIDGE DR., BETHESDA, MD 20817 ELIZABETH I. SALTER/ DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition JUNE 30 20c. Location - City or Town, State 1 ☐ Burlal 2 X Cremetion 3 ☐ Removal from State NATIONAL CREMATORY 2000 FALLS CHURCH, VA 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility DANZANSKY-GOLDBERG MEMORIAL CHAPELS, 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdlac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical SEPSIS Examiner Due to (or as e consequence of): Physician/Medical Examiner The law requires that the death certificate be executed ettending physician and for use as the bunel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): P.O. Box 68760 that initiated events resulting in death) Last Due to (or as a consequence of) n signed by the e 23b. Did tobacco usa contribute to the cause of death? Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ been sig 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24a. Was an autopsy performed' page 2 : r this certificate haral director, page 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: Be 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 XNo 1 XInpatient 2 ER/Outpatient 3□ DOA funeral 27. Menner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 1 Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No death. investigation Director: / 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Direc 4 Homicide in 24 hour. the Funeral Directory filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) end manner stated. To the Hosp within 24 hou To the Funer completely fil edicai 29a Certifier 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) 97-01873(NC) 28 30 address of person who completed cause of deeth (Item 23e) (Type, Print) NATIONAL NAVAL MEDICAL CENTER BETHESDA MD 20889-5600 JOSEPH J. SPOSATO, LT, MC, USNR 32. Registrar's Signature 31. Dete filed (Month, Day, Year) State JUN 3 0 2000 souls Registrar



State of Maryland / Department of Health and Mental Hygiene

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al	Social Security Number 6.	Sex 7. Age ((In yrs. lest birth	Months	r 1 Year Deys	if Under 2 Hours	Min.	8. Date of Bird (Month, De	th y, Year)	9. Birthpia	ce (State or Fore
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ctc	Virginia Fairfax		Falls C								
Director	10e. Street end Number			10f. Zij	p Coda				10g. Citizen of	What Country	n
Ta .	7218 Timber Lane				046				USA		
Jue .	11. Marital Status	12. Was Decedent Ev Armed Forces?	er in U,S.	Was Deca If Yes, ape	dent of Hi cify Cuba	ispenic Orlg n, Maxican,	in? (Spec	cify Yes or No Rican, etc.)		ce - American ick, Whita, etc	
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JUNE 24, 2000 11:55 AM ADOLPH ROSENZWEIG 4c. County of Death MONTGOMERY 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street and number) BETHESDA SUBURBAN HOSPITAL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) NOV. 19, 1911 5. Social Security Number Birthplace (State or Foreign Country) NY 6 Sax 7. Age (In yrs. last birthday) Months 1 M 2□ F Yrs. 88 057.01.7253 Usual Residenca of Decedent 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 No ROCKVILLE MONTGOMERY 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20852 6121 MONTROSE ROAD 12. Was Decedent Ever In U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Biack, White, etc. 11. Marital Status 1 Never Married 20 Merried Specify: WHITE 1 ☐ Yes 2 ☒ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eiementary/Secondary (0-12) College (1-4or 5+) FURNITURE SALESMAN 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) YOLAN ROSENZWEIG MICHAEL ROSENZWEIG 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MONTHY WITH VINERY VITTLAGE, MD 20886 19a. Informant's Name/Relationship (Type, Print) 7502 OYSER BAY WAY, MONTGOMERY VILLAGE, MD BEN ROSENZWEIG/SON 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1X Burial 2 ☐ Cremation 3 ☐ Removal from State JUDEAN MEMORIAL GARDENS 6.26.2000 OLNEY, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EDWARD SAGEL FUNERAL DIRECTION, INC. 20852 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ACUTE CONGESTIVE HEART FAILURE CORONARY ARTERY DISEASE Due to (or as e consequenca of): Due to (or as a consequence of) 23b. Did tobecco use contribute to the cause of deeth?

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Director

Funeral

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Completed

Be

Funeral

Director

than "natural", or ltams 23s or 28s-f shorthe Medical Examiner must be notified at

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If them 27 is marked oths any Injury or other traumatic event.

the Maryland

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filed within

Baltimore, Maryland 21215-0020

Examiner sicien and burial-transit attanding physicien for use as the buria Physician/Medicai ed by the a þ

The law requires that the death cartificete be executed signed t peen hes paga cartificata Physician: funaral director, this Aftar Attending deeth. after deeth Director: tha 2 24 hours after Funeral Dire letely filled in b

Division of Vital Records, P.O. Box 68760.

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given In Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other. 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 28c. Injury at Work? 5 Pending Investigation 1 Natural 1 Tyes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier edicai **Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end manner stated. (Check only one) 29b. Signature and two certifier

29c. License number

D05885

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

MONTROSE ROAD, ROCKUILLE STEVEN 6121 31. Date filed (Month, Day, Year)

State Registrar

JUN 2 7 2000

32. Registrar's Signature

SonMD

To the Hosp within 24 hor To the Fune completely fi

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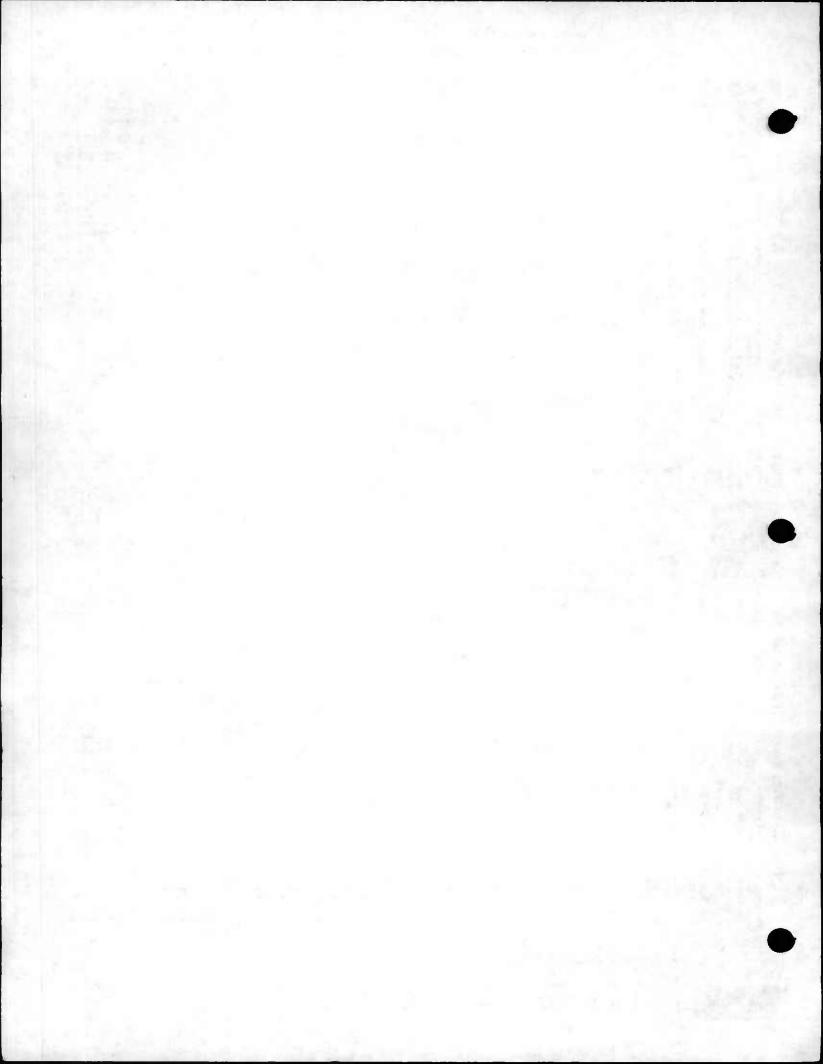
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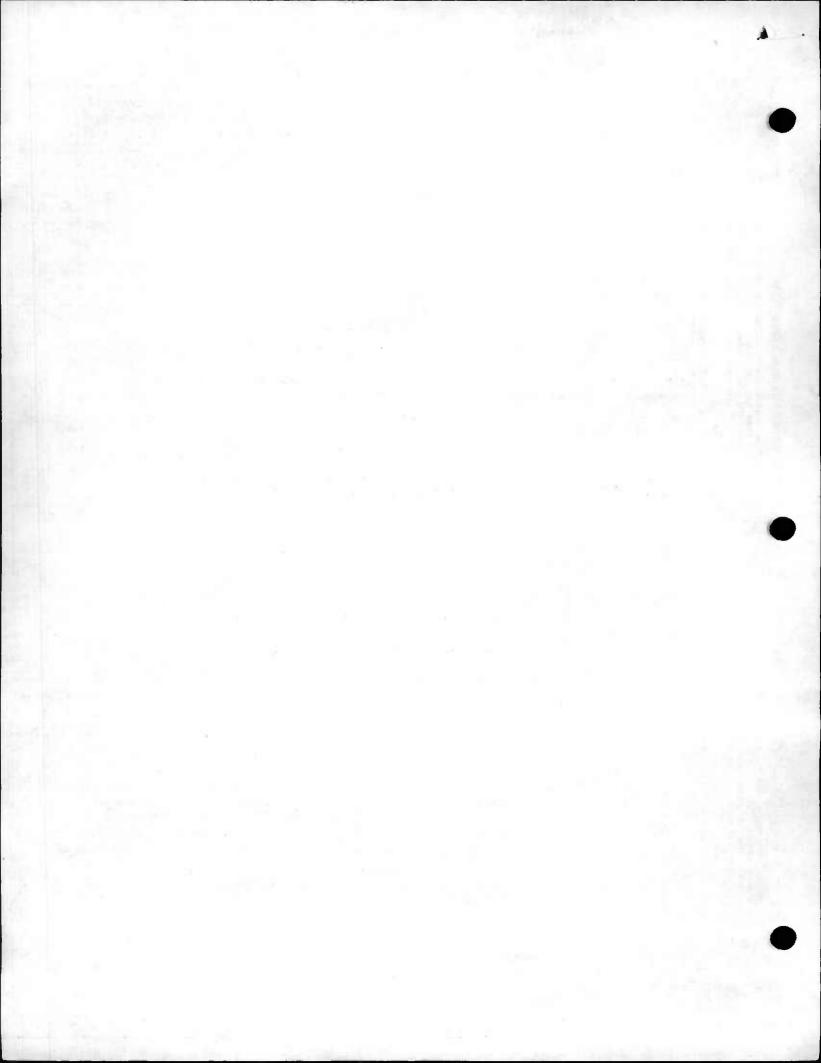
State of Maryland / Department of Health and Mental Hygiene 10 0 22006

			Certifica	te of Death	Re	eg. No.	22000
1,	1. Decedent's Name (First, Middle, L.	ast)			2. Data of Deat Month	h	3. Time of Death
nysician Medical	Robert	Lee Roya	1, Sr.		June		000 3:00 AM
xaminer	4a Facility Name (If not institution, gi	ve street and number)		4b. City, Town, or	Location of Death	4c. County o	f Death
	SHADY GRO	VE ADVENTIS	T HOSPITA	L ROC	KVILLE	MON	TGOME RY
neral		Sex 7. Age (In yrs	Month	er 1 Year If Under 24 Hr s Days Hours Mir		Year)	Birthplace (State or Foreig Country)
ector	577-26-5328	TIAM 20 F	75 Yrs.		April 1	6,1925 W	lashington, D
	Usual Residence of Decedent 10a. State 10b. County	10c. C	City, Town or Location				10d. Inside City Limit
5							1 ☐ Yes 2 ☒ N
be notified Director	Maryland Montgon	nery	Germantown	ip Code		Og. Citizen of Wi	hat Country?
4 5	10 20000 10 000		101. 2				
era e	21 Sunnyview Cou	12. Was Decedent Ever in	IIS 13 Was Dec	20876		United	States - Amarican Indian,
Examiner must be notified at by Funeral Director	1 Never Married 2 Married	Armed Forces? 1 ☑ Yas 2 ☐ No	If Yes, sp	edent of Hispanic Origin? (pecify Cuban, Mexican, Pue	rto Rican, etc.)		White, etc.
by	3 □ Widowed 4 □ Divorced	If Yes, Give Year or Dates: 1942	1 Yes	2 No Specify:		Specify:	White
edical Exp	15. Decedent's E	ducation	16a. Decedent's Us	ual Occupation		16b. Kind of Bus	
r, the Medical	(Specify only highest gr Elementary/Secondary (0-12)	rade completed)	(Give kind of v	vork done during most of wo use retired)	orking		DC COTOC.
E E	Elementary/Secondary (0-12)	Collega (1-4or 5+)	Field Ser	vice Manager		Busines	s Machines
event, Be C	17. Father's Neme (First, Middle, Las	0			ame (First, Middle, A		
To B	Stephen	Robert Royal			Margar	et El	llis
T	19a. Informant's Name/Relationship			ss (Street and Number or I			
7	Mary A. Royal/Wif	e	21 Sunnyy	iew Court, G	ermantown	. Marvla	and 20876
lary or other treumetic even	20a. Method of Disposition		Place of Disposition (A	ame of			City or Town, Stata
٧ م	1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special Control of Cont		cemetery, crematory of		6/23/00 4	lovandr	ia, Virginia
יילי	21. Signature of Funeral Sarvice Lice		tropolitan	and Address of Facility	0/23/00 A	Texaliui	ia, viiginia
eny injury o	21. Signature of Political Salvice Lice	Th () 00			eVol Fune		
	1/ well	< Onn		st Deer Park			
	23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused the dea y one cause on each line.	ath. Do not enter the m	ode of dying, such as cardi	ac or respiratory arre	est,	Approximata Interval Between
cian							Onset and Death
dical niner	Immediate Cause (Final disease or condition	Pneumonia					3 weeks
	resulting in death)	Due to	(or as a consequence o	1):			
tal-transit Examiner		Radiation	Pneumonitis	3			2 months
s the burial-transit	Sequentially list conditions,	Due to	(or as a consequenca o	f):			
	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Lung Cance	r				10 months
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etached for us Physician	Part II. Other significant conditions	contributing to death but not ra	sulting in the underlying	cause given in Part I.	23b. Did to	bacco use conf	ributa to the cause of dear
y Physic					1 🗆 Y	es 2 No	3 Probably 4 Unknown
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Page					1 <u>√</u> 2 Ye	s 2 No	1 ☐ Yas 2 ☐ No
ō ø	25. Was case referred to medical examiner?			26. Place of D	eath (Check only on	(e)	
9 0	1 Yes 2 No	Hospital: 1 1 Inpatiant 2	☐ ER/Outpatient 3☐	DOA Othar: 4 Nursing	Home 5 ☐ Reside	nce 6 Othe	r (Specify)
1 (0)	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	28d. Describe ho	ow injury occurre	d
led in by the funera Certification:	2 ☐ Accident investigation		М	1 ☐ Yes 2 ☐ No			
by t	3 Suicide 6 Could not I determined		home, farm, street, factorify)	ory, office	281. Location (St City or Town		r or Rural Routa Number,
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Sai of		hysician: To the best of my kn miner: On tha besis of axamin					
completely filled in by the funer Medical Certification:	one)	and manner stated.	ation and of invastigation	on, in my opinion, death oc	sorred at the time, di	ate and place, a	id dde to the cause(s)
eld moo	29b. Signature and title of certifier	1 1	. 2	9c. Licanse number	2	9d. Date signed	(Month, Day, Year)
H	1 found H.	rule ms		D 47791		June 22,	2000
("	30. Name and address of person who	completed cause of death (Ite					
	David A. Holden,	M.D. 809 Veirs	s Mill Road	, Rockville,	Maryland	20851	
State	31. Date filed (Month, Day, Year)	32. Registrar's Sign		-			
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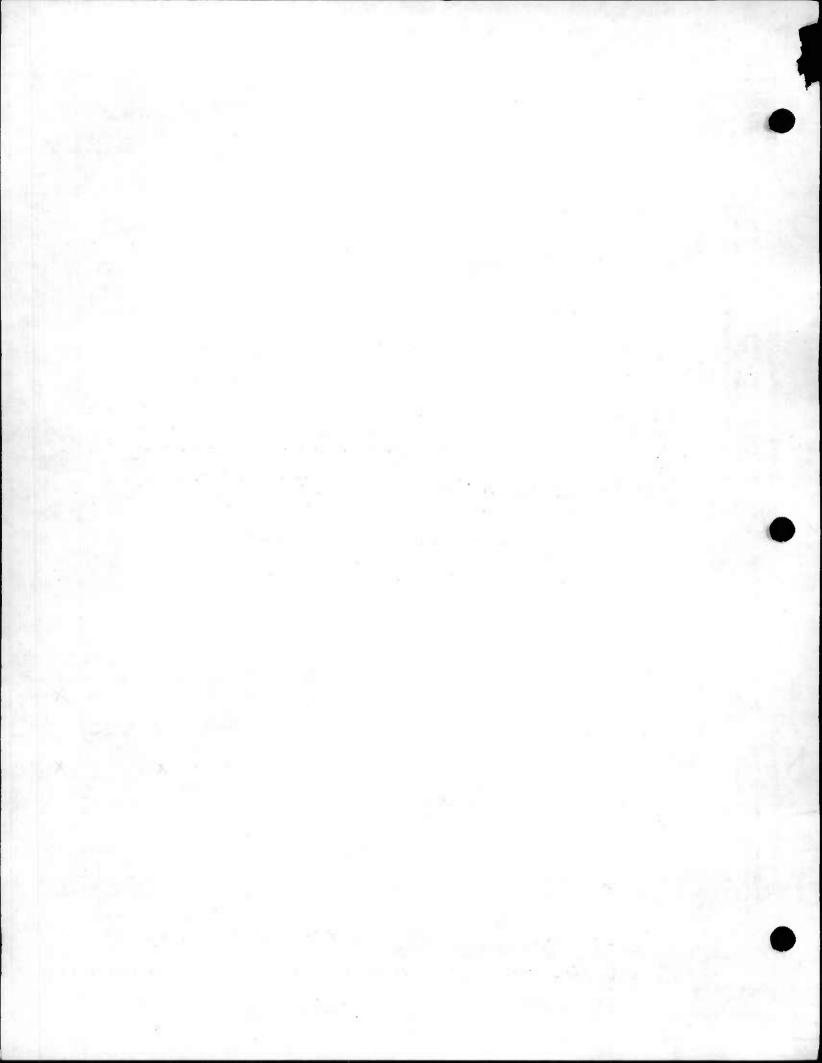
State of Maryland / Department of Health and Mental Hygiene 22007 Amend #28a,c,d,e,6/28/2000, BMW, Montg.Co. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** RUEBENS MARTIN 06 21 12.55 AM 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** SILVERSPRING HOLYCROSS HOSPITAL. MONTGOMERY | H Under 1 Year | H Under 24 Hrs. | B. Date of Birth | Months | Days | Hours | Min. | Nov 16, 1924 | Pennsylvania 5. Social Security Number 6. Sex 1 → M 2 □ F 7. Age (In yrs. last birthday) **Funeral** 75 Yes. 180-16-5554 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2X No Directo Stafford Stafford Virginia or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Berns 23a 22554 2030 Admiral Drive Funeral permit. Pages 1 and 2 should be filled within 72 hours after deal Depostment of Health and Mernal Hygiene. Important: if item 27 is marked other any injury or other transfer other any injury or other transfer. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Maritel Status Armed Forces?

1 XYes 2 No 1942—
If Yes, Give
Year or Dates: 1966 1 ☐ Never Married 2 X Married Specify: White 1 Yes 2 No Specify: à 3 ☐ Widowed 4 ☐ Divorced 1966 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Director of Health Care U.S. Coast Guard 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gertrude Frankel Morris Ruebens 19a. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mark A. Ruebens (son) 3020 Shanandale Drive, Silver Spring, MD 20904 20b. Placa of Disposition (Name of cametery, crematory or other placa) Date 6/29 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cemetery 2000 Arlington, VA 21. Signature of Fuheral Service Licensee 22. Name and Address of Fecility Francis J. Collins Funeral Home, Inc. o ber Kan ace 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth on not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heert failure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical RESPIRATORY Examiner Due to (or es e consequence of): Physician/Medical Examiner MALIUNANT PLEURAL EFFUSION ed by the attending physician and detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated many) Due to (or as e consequenca of): Box 68760, STAGE NON HOPLKINS LYMPHOMA END that initiated events resulting in death) Last Due to (or as e consequença of): CONHECTIVES HERRIT FAILUNE Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy tindings available prior to completion of cause of death? is certificate has been si director, page 2 should Be Completed 24e. Was an eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 28 No Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Ves 2 No edical Certification: To this funeral 28c. Injury at Work? 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 5 Pending investigation 1 Netural To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af completely filled in by the fu death. 1 Yes 2 No -1914 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stele) 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1.2. Certifying Physician: To the best of my knowledge, death occurred at the time, dete end place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examinetion and/or Investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and manner stated. 29b. Signeture end fitte of certifier 29c. License number 29d. Date signed (Month, Day, Year) Wheele Authory M.0 10+1 20051158 06 | 22 | 2000 30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print) ROCKUILLE MO 20850 . T. ANTHONY M.D ; 2401 RESEARCH BLUD # 102 31. Dete filed (Month, Day, Year)
JUN 2 8 2000 32. Registrer's Signeture State oaks Registrar



State of Maryland / Department of Health and Mental Hygiene

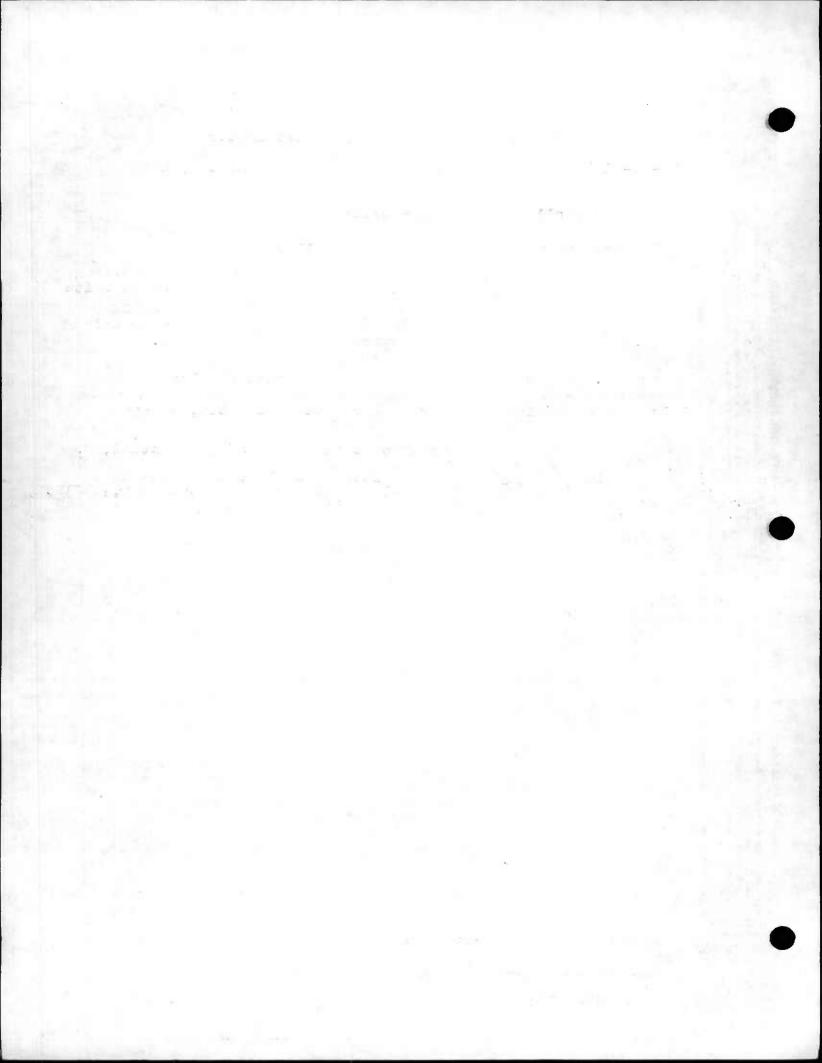
			Ce	rtificate of	Death		Reg. No.	00 2	2008	
Dharaisisa	1. Decedent's Neme (First, Middle, La					2. Dete d	of Deeth	Year	3. Tima of Death	
Physician /Medical	Stewart Randa	ill Stinchcom	b, Sr.			June		2000	9:53 PM	
Examiner	4e Facility Neme (If not institution, giv	e street and number)			4b. City, Town,	or Location of I	Death 4c. (County of Death		
	Northwest Hospi			I Williams & Von		.1stown		Baltimo		
Funeral Director	5. Social Security Number 6. S 219-30-1448 Usual Residence of Decedent	ex 7. Age (In y	rs. last birthday) 66 Yrs.	If Under 1 Yea Months Days		Ain. (Monti	of Birth h, <i>Day</i> , Year) 19 19	Cou	plece (Stete or Foreigntry) Tyland	
dand dand	10a. Stete 10b. County	10c.	City, Town or Lo	ocation					10d. Inside City Limit	
vith the Maryland t or 28a-f show be notified at Director	Maryland Baltin	nore	Randall:	Stown 10f. Zip Code			10a Chir	en of What Cou	1 ☐ Yes 2 🖾 No	
eth with	3705 Lanamer Roa			211			Unit	ed State	es	
72 hours after deeth with the Maryland natural, or items 23s or 28s-f show diest Examiner must be notified at each by Funeral Director	11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced	12. Wes Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:		Wes Decedent of If Yes, specify Cu 1 ☐ Yes 2√☐4No	ban, Mexican, P	r (Specify Yes o uerto Rican, etc	.)	4. Rece - Ameri- Bleck, White, Specify: Wh		
ed within 72 ho yglene. wr then "natura ft, the Wedical Completed	15. Decedent's Ed (Specify only highest gre		16a. Dece	dent's Usuel Occu	pation during most of	working	16b. Kin	d of Business/In	dustry	
filed within Hygiene. ther then end, the west	Elementery/Secondary (0-12)	College (1-4or 5+)		kind of work done DO NOT use retir				0 - 1		
filed with Hygiene the ther the	6th		She	affer Ea	1		intelle Administration of	Sales		
0 2 0 5 0	17. Father's Name (First, Middle, Last) Maurice Stinche					Neme (First, Mi		oumeme)		
aith end 27 is me traum	19a. Informent's Neme/Reletionship (Sandra Lee Stincl			ng Address <i>(Stree</i> Lanamer		r Rural Route N Randall			133	
of Herm	20e. Method of Disposition		. Pleca of Dispo	osition (Name of metory or other pl	ece)	Date	20c. Loc	cation - City or To	own, Stete	
Page nent: H	1 Suriel 2 □ Cremetion 3 □ 4 □ Donetion 5 □ Other (Specif.	y) L	ake Vie	w Memori	al Park	6/22/2	2000 s	ykesvil.	le, MD	
permit. Pages 1 and 2 should be Department of Health end Merit important: if item 27 is marked eny Injury or other treumetic endice. TO E	4 Donetion 5 Other (Specify) Lake View Memorial Park 6/22/2000 Sykesvil 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, M									
	23a Part Enter the disease, or com	plicetions that reused the de						Terd, it	Approximete Interval Between	
/Medical Examiner per per per per per per per per per p	Immediate Cause (Final disease or condition resulting in deeth)	8.	cleroti (or es e conse	c Cardio	vascula	r Diseas	se			
nta be nysicia he bur	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting In death) Last Due to (or es e consequence of): Due to (or es e consequence of):									
nding use as	L	d								
the atter the atter thed for u	Part II. Other significant conditions of	ontributing to death but not i	resulting in the u	inderlying cause g	iven in Pert I.	23b.	Did tobacco	uss contributs t	o the cause of death	
d by detac	Diabetes Melitu	s					23b. Did tobacco use contribute to the cause 1 Yes 2 No 3 Probably			
aw requisite the state of the s	Morbid Obesity					24a.	Wes en eutop: performed?	91	fere eutopsy findings yellable prior to empletion of cause deeth?	
The la							1 □ Yes 2	(No 1	☐ Yes 2 No	
ystcien: The is certificate director, pag	25. Was case referred to medical exeminer?				26. Place of	Death (Check of	only one)			
Physicien: this certific ral director. : To Be (1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2	ER/Outpatie	nt 3 DOA	ther: 4 Nursir	ng Home 5□	Residenca 6	☐Other (Speci	(h)	
Attending Ph ir deeth. ector: After th by the funeral	27. Manner of Death 1. Neturel 5 Panding 2 Accident investigation	28a. Dete of Injury (Month, Dey Year)	28b. Time of Injury	W	uryat ork? ⊒Yes 2 ☐ No	28d. Desc	ribe how injury	occurred /		
be or Attending P as after death. In Director: After t led in by the funers Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Plece of Injury - A building, etc. (Spe	t home, ferm, st	reet, fectory, office	9		ion (Street and or Town, Stete)		al Route Number,	
Hospi 24 hours Funst stely fill	29a. Certifier (Check only one) Certifying Ph	ysician: To the best of my k niner: On the basis of exam end menner steted.	nowledge, deat inetion end/or In	h occurred et the vestigation, in my	time, date and pi opinion, deeth o	lace, end due to	the cause(s) ime, dete end	and menner as a pleca, and due t	stated. o the cause(s)	
within To the comple	29b. Signeture end title of certifier			29c. Licer	nse number		29d. Date	signed (Month,	Day, Year)	
	1 MAS N	57		D4	7587		JUN	€ 17. 2	000	
	30. Name and address of person who ROBEM FINE	· ·	tem 23a) (Type,		-	PANDAL				
State Registrar	31. Dete filed (Month, Dey, Year) JUN 2 6 2	32. Registrer's Sk	neture	100	1					



State of Maryland / Department of Health and Mental Hygiene

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1.1			Certifica	te of Death		Reg. No.	Con Long	
-	Decedant's Nama (First, Middle, Las	1)			2. Deta of Do	eeth Dev	3. Tir	ne of Death
	Tames (e	Cil In	uder		Tune		2000 (1642
4a	Facility Name (If not institution, give	street end number)		4b. City, Town, o	r Location of Deal			
	CADROLL CN	intu b	LOS Pita	Westm	inster	Cal	naid	
5. 5	Social Security Number 6. Se		s. last birthday) If Und			nth	9. Birthplaca (Si	ete or Forei
			Yrs. Months	B Days Hours Mi	n. (Month, D	By, Year)	Country)	MD
-	ual Rasidanca of Decedant	U			Sept	27 193)	MID
_	a. Stata 10b. County	10c. C	City, Town or Location				10d. insi	de City Limit
	MD G	7	M = - 1 1					Yas 2□N
	MD Carrol		Manchest					
10€	a. Street and Number		10f. Z	ip Code		10g. Citizen of V	Vhat Country?	
2	2909 Park Aven	ue		21102		USA	A.	
11.	Marital Status	12. Wes Decedent Ever in Armed Forcas?	U,S. 13. Was Dec	edent of Hispanic Origin? ecify Cuban, Mexican, Pu	(Specify Yas or N	o- 14. Race	a - Amarican India	ın,
	1 Nevar Married 2 Married	1 ☐ Yas 2 ☑ No			erto rucan, atc.)		k, Whita, atc.	
	3 ☐ Widowed 4 ☐ Divorced	If Yas, Giva Yaar or Datas:	1□ Yas	2☐xNo Specify:		Specify	. Whit	е
	15. Decedant's Ed	ucation	16a. Decedent's Us	ual Occupation		16b. Kind of Bu	isinass/Industry	
	(Specify only highest gred	de completed)	(Give kind of w	rork done during most of w use retired)	vorking	Snyder		
F	Elamantary/Secondary (0-12)	College (1-4or 5+)	Owner			Inc.	. Down	
	12		Owner					
17.	Fathar's Nama (First, Middle, Last)			18. Mother's N	ama (First, Middle	, Maiden Sumem	(0)	
(George C. Snyd	.er		Maxi	ne Whee	ler		
19	a. informant's Name/Relationship (T	ype, Print)	19b. Mailing Addres	ss (Street and Number or	Rural Route Numb	er, City or Town,	State, Zip Code)	
Do	olores Snyder/	wife		ck Ave Man				
_	a. Mathod of Disposition		Place of Disposition (N	ame of	Data		City or Town, Sta	le .
	Burial 2 Cramation 3 🗆	Ramoval from Stata	cemetery, cremetory or	other place)	307785			17
	4 ☐ Donation 5 ☐ Othar (Specify	n	Greenmount	t Cem	6/23	Hampste	ead, MD	
21	Signature of Funeral Service Licens	sep , 1		and Addrass of Facility				
	1/1/1	171/1		ts Funeral				
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State of Maryland / Department of Health and Mental Hygiene

			Cer	tificate of	Death		Reg. No.	0 55010
Physician	1. Decedent's Nama (First, Middla, L	ast)				2. Data of De	eath Day	3. Tima of Dea
/Medical	JEREMIAH	WILLIAM	SNYI	DER		JUNE	14 2	000 7;30 A
Examiner	4a Facility Nama (If not institution, g					or Location of Daat	,	
	Frederick Memor	-		If Under 1 Yaar	Frederi			erick County
Funeral Director	189-09-6826	Sex 7. Age (In yr	s. last birthday) 9() Yrs.	Months Days		Hrs. 8. Data of Bli Min. (Month, Do May 30	y, Year)	9. Birthplaca (Stata or For Country) Maryland
3_	Usual Rasidance of Dacedent 10a. Stata 10b. County	10c. (City, Town or Lo	cation				10d. Insida City Li
tiffed at	Maryland Frederi	1			rmitsbu	rg		1 □ Yas 2 🔀
23a or 28a-fa ast be notified al Director	10e. Street and Number 16405 Tom's Cr	eek Church Roa	d	10f. Zip Coda	2172	7	10g. Citizen of V United S	
natural, or tems 23s or 28s-1 show to call a reduced at solution at letter by notified at letter by Funeral Director.	11. Marital Status 1 Navar Married 2 Married	It Yas, Giva		Vas Decedant of Yas, specify Cut		? (Specify Yas or No uarto Rican, atc.)	Blac	a - Amarican Indian, ck, Whita, etc. White
eal Eran	3 Widowed 4 Divorced	Year or Dates:	16a. Deced	lant's Usual Occu	pation			usinass/Industry
	(Specify only highast g	rada complated) Collega (1-4or 5+)	(Giva lifa. L	kind of work done OO NOT use retire	during most of d)	working		
t, he Medical Completed	9	Collega (1-4or 5+)	fact	ory work	er		rubber	manufacture
Went Be C	17. Fathar's Nama (First, Middla, Las				18. Mothar's	Nama (First, Middle	, Maidan Suman	na)
To	Clarence Orvi	lle Snyder			Elli	e Elizabe	th Houck	2
and	19a. Informant's Name/Relationship Lena A. Snyder /					urch Road		Stata, Zip Coda) Sburg, MD 21
important: If frem 27 any Injury or other tr once.	20a. Mathod of Disposition 1 🖾 Burial 2 □ Cramation 3 4 □ Donation 5 □ Other (Spec	□Ramoval from Stata		sition (Nama of natory or other pla Union (June 17 2000		city or Town, Stata , Maryland
mportant: If it any injury or c	21. Signatura of Funaral Sarvice Lic	enspe				Skiles Fu		
) = 4 O	Slam ()	M01072	2 13	6 East 1	salt1mor	e Street	Taney	town, MD 2178
n end iel-transit Examiner	Sequentially list conditions,	b. Due to	(or as a conseq	uance of):				1
physicien is the burial edical Ex	Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Causa (Disease or injury that initiated avants	C. Due to	(or as a consequ	uanca of):				
OI III DO	rasulting in death) Last	d	(or as a consequ	darica org.			4	
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has been ge 2 should mpletec	X DDD	pringice	ney		14.0			complation of cause of death?
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ral dire	27. Mangar of Death	1/2 Inpatient 2	☐ ER/Outpatien 28b. Time of	ADD DOW	4 LI NUM	ng Home 5 ☐ Res 28d Describe	how injury occur	and the second of the second o
After	to Natural 5 Pending 2 Accident invastigati	28a. Date of Injury (Month, Day Year)	Injury	W	rk?]Yes 2∐No			
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To the Funeral Dir completely filled in	29a. Certifier Check only one) 2 Medical Exp	hysician: To the best of my kiminer: On the basis of axami	nowiedge, death	occurred at the trastigation, in my	ime, date and p opinion, death o	lace, and due to that occurred at the time,	causa(s) and mi date and placa,	annar as stated. and due to the causa(s)
Mec Mec	29b. Signa vra and titla of certifier	and manner stated.		29c. Lican	sa number		29d, Date signe	d (Month, Day, Year)
3 ⊢ 8	MINTER	2		D2	6516		JUNE	14 2000
	30 Name and address of person with	completed causa of daath (It	em 23a) (Type, I	Print)	1 1	CON A	A 7	
	Allen J. Calo	W 10 14	75 TA	NEY	HIE 1	THED M	1) 212	402



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) 1⁵, 2000 Jwne 9:26am STONESIFER FRANCES BARRICK 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Walkersville Glade Valley Nursing & Rehab. Ctr Frederick If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) Mar. 31, 1916 9. Birthplace (State or Foreign Country)
Maryland 7. Age (In yrs. last birthday) 5. Social Security Number Months Hours 1 M AFF Yrs. 84 217-62-7436 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Carroll Keymar 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 2017 Reifsnider Rd. 21757 IISA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White 1 ☐ Yes 2√2 No Specify: 3 ₩ Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Melden Sumeme) Harry Barrick Carrie Hinea 19a. Informent's Name/Relationship (Type, Print) 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James H. Stonesifer/Son 13901 Motters Station Rd., Rocky Ridge, MD 21778 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State to Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 06/20 Grace UCC Cemetery Taneytown, MD 21. Signature of Funeral Sarvice Licansee 22. Name and Address of Facility Skiles Funeral Home 23a Park Enter the disease, or complications that caused the deeth. 136 E. Baltimore St. Taneytown, MD 787 Approximate Intervet Between Onset end Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last eacs Part tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 Yes 1 Tyes 2 TNo 26. Place of Death (Check only one) Other: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No

Physician /Medical Examiner physician and s the buriel-transit The law requires that the death certificate be execu

Physician

/Medical

Examiner

Directo

Funeral

2

Completed

Be

2

10a. State

Maryland

11 Marital Status

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 23a-4 show any injury or other traumstic event, the Medical Examiner must be notified at

altimore, Maryland 21215-0020

Examiner USB 88 Po signed by the a director, filled in by the luneral

Medicai

Physician/Medical þ Completed Be 2 Certification:

certificate has

After this

24 hours after deeth. Funeral Director: Af

To the Hosp within 24 hou To the Fune completely fil

Hospital or Attending Physician:

Division of Vital Records, P.O. Box 68760,

25. Was case referred to medical examiner? 26 No 1 Yes

27. Magner of Death Neturel 2 Accidant

29a. Certifier

29b. Signal

6 Could not be determined 3 Sulcide 4 Homicide

re and fitte of certifier

Place of Injury - At home, farm, straet, factory, office building, atc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and menner stated. 29d. Date signad (Month, Day, Year) 29c. License number

2000

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1	11	YOU	1.	(71	C.	leted cause o	14	157	41

31. Date fited (Month, Dey 32. Registrer signeture 16 2000

FRED

State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended item# 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2000

3. Time of Death

Physician

Physician /Medical	MARVIN HERBERT	SEDON			June	12, 20	00 0437
Examiner	An Emplify Alama (Manakin attendentary at)	street and number)		4b. City, Town, or Lo	cation of Death	4c. County	
	Homewood at Cruml	and Farms		Frederi		Frede	rick
Funeral Director	5. Social Security Number 6. S 370-03-7986	ex. 7. Age (In yrs. last	t birthday) If Under 1 Yea Months Deys		8. Dete of Birth (Month, Day, July 5,	Year) 1918	Birthplece (Stete or Foreign Country) Michigan
P	Usual Residence of Decedent 10e. Stete 10b. County	10c City 1	Town or Location				10d. Inside City Limits
aho							1 ☐ Yes 2 No
or 28a-fs	Maryland Frederic	K Fred	lerick		110	0g. Citizen of V	Vhet Country?
A S S	7407 Willow Road		2170	2		U.S.A	
r tems 23s	11. Marital Status	12. Was Decedent Ever in U,S.	13. Wes Decedent of If Yes, specify Cul		cify Yes or No-	14. Rac	a - American Indian,
by by	3 ☐ Widowed 4 ☒ Divorced	Armed Forces? 1 ②Yes 2 □ No If Yes, Give Year or Dates: WWII	1 ☐ Yes 2 ☐ No		Hican, etc.)	Specify	k, White, etc. White
72 hours natural;	15. Decedent's Ed (Specify only highest gra	lucation de completed)	16a. Decedent's Usual Occu	pation	00	16b. Kind of Bu	siness/Industry
ed within 72 ho yglene. Ar then "neturin, ft, tre Worlder	Elementary/Secondery (0-12)	College (1-4or 5+)	(Give kind of work done life. DO NOT use retire		9		
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s 1 end f Health frem 27 other tr	Douglas N. Sedon		2815 Fry Road				
2 2 2 2 2	20a. Method of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Specify	Hemoval from State	a of Disposition (Name of letery, crematory or other plants or nate. C		/30/00 A		On • VA
pemit. Pe Departmen Important: any injury Bitca.	21. Signature of Flineful Service Liber	Haileel VI		ress of Fecility DAILEY & H MARKET S			MD 21701
Physician	23a Part Enter the disease or com- shock, or <u>kean failure</u> . List only	pine cause on each line.	Do not enter the mode of dy	ing, such as cardiac o	or respiratory arre	est,	Approximate Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition	· ASCV	D				Years
Service Control	resulting in death)	Due to (or e	s e consequence of):				
nin isi		· Deme	ntia				Years
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centific nding	L	d					
deeth certi	Part II. Other significant conditions or	ontribution to death but not resulting	ng in the underlying cause of	iven in Part I	23b Did to	hacco use co	ntributs to the cause of death?
by the	and a grinount containing of	Annount of the double of the treatment	ig in the underlying outdoor	IVOIT III T GILLI.		88 2 No	
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stan: Stan: Stan: Stan: Stan: Be C	25. Was case referred to medical			26. Place of Deatl	(Check only on	16)	
hysici nis ce il direc	axeminer? 1 X Yes 2 □ No	Hospital: 1 ☐ Inpatient 2 ☐ ER	VOutpatient 3 DOA	ther: 4 Nursing Ho	me 5 Reside	ence 6 Oth	er (Specify)
oding Ph ith. After the funeral	27. Manner ot Death 1 Natural 5 Pending 2 Accident investigation	(Month, Day Year)	Bb. Time of linjury 28c. Inj W	ury at ork? Yes 2 100	28d. Describe ho	ow injury occur	red
To the Hospital or Attending Physician: The law within 24 hours effer death, To the Funeral Director: Atter this certificate has completely filled in by the funeral director, page 2 Medical Certification: To Be Comp	3 Suicide 6 Could not be determined		e, farm, street, factory, office		City or Lowi	n State)	oer or Rural Route Number, ane Frederick
he Hospit In 24 hour he Funera pletely fill edical	29e. Certifier (Check only one) 1 Certifying Physical Example 2 Medical Example 2	ysician: To the best of my knowle liner: On the basis of examination and manner stated.					
ro the within complex complex Me	29b. Signature and title of certifier		29c. Licer	nse number	2	9d. Date signe	d (Month, Day, Year)
F > F 0	Mushin	tothe	. D3	5164		June	13,2000
•	30. Name end address of person who o	completed cause of death (tem 2)					

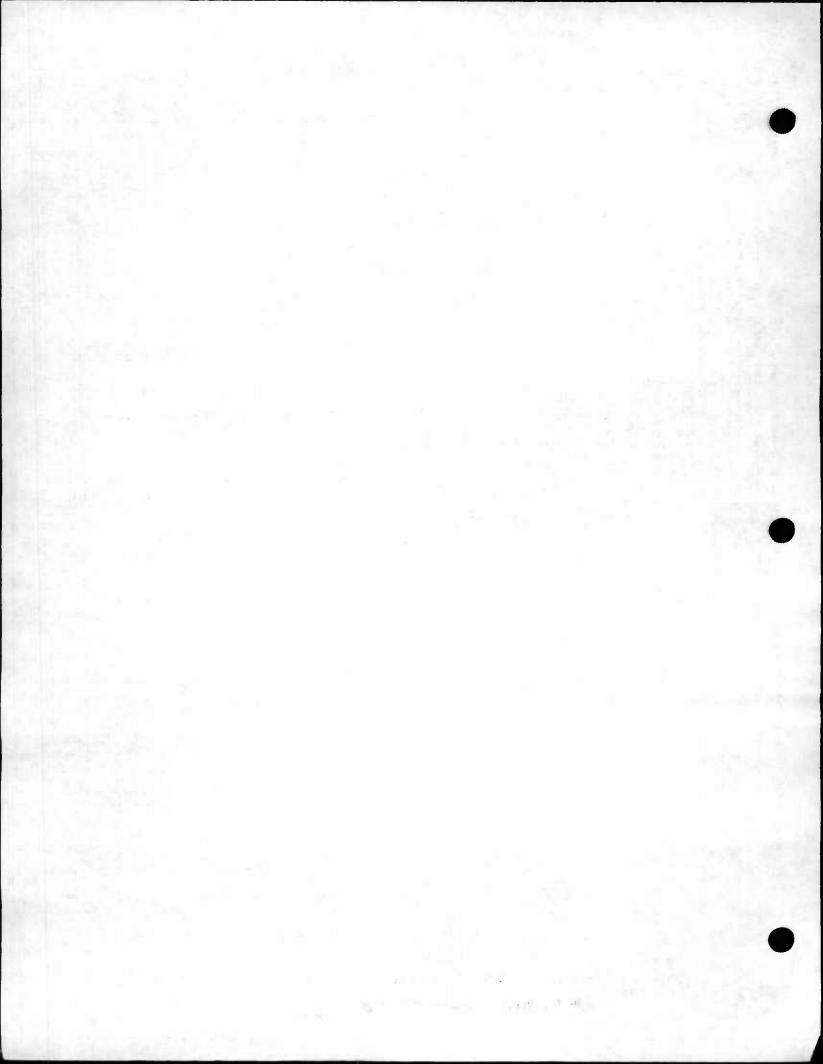
DHMH 16 Rev 6/95

State Registrar

Andrew Zarick, MD

31. Date filed (Month, Day, Year) 1 4 2000

1080 West Patrick Street, Frederick, Maryland 21701



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 22013

	Decedent's Name (First, Middle, Last)										3. Time of Death	
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al	5. Social Security Number	6. S			s. last birthdey	() If Under 1 Y	ear If Unde	er 24 Hrs.	8. Date of Birth (Month, Dey,			place (Stata or Foraig
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þ	3 ☐ Widowed 4 ☐ Div	-	If Yes, Giv Year or D	/e	т	1□ Yas 2⊠	No Specif	y:		Specia	y: Wh:	ito
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State of Maryland / Department of Health and Mental Hygiene 22014 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Dev **Physician** 19, RICHARD С. SHANKLE 2000 June 5:00 A.M. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 9314 Links Road Walkersville Frederick If Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Min. Days Months Hours 12 M 2 F 220-18-1706 72 Director Maryland Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits or Items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Frederick Walkersville 10e Street and Number 10a, Citizen of Whet Country? 10f. Zip Code 9314 Links Road 21793 Funeral pemit. Pages 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Itema 23 any Injury or other traumatic event, the Medical Examinat mater United States Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Spacify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: WWII 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Completed by Specify. 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Staff Sergeant 12 U.S. Army 17. Father's Nama (First, Middla, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) Be Clarence Shankle 2 Daisy Holt 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) Sarah I. Shankle / Wife 9314 Links Road, Walkersville, Maryland 21793 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State June 22 4 □ Donation 5 ☑ Other (Specify) Entombment Resthaven Memorial Park 2000 Frederick, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of uparal Sarvice Licensee 1621 Opossumtown Pike, Frederick, Maryland 21702 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervat Between Onset and Death **Physician** /Medical Immediate Cause (Finel TPOXIA disease or condition resulting in death) Examiner HRONIC PUL MONARY DISEASE OBSTRUCTIVE The law requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760. physician Pulmonon Physician/Medical Due to (or as a consequence of Smoking signed by the atter Part II. Other significant conditions contributing to death but not resulting in the undarlying cause given in Part I. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown þ 24a. Was an autopsy parformed? 24b. Were eutopsy findings available prior to complation of causa of death? Completed 1 ☐ Yas 2 ☐ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home To Residenca 6 ☐Other (Specify) this funaral 28a. Date of Injury (Month, Day Year) Manner of Death Certification: 28c. Injury at Work? 28d. Describe how Injury occurred Aftar 5 Pending Investigation To the Hospital or must within 24 hours after death.
To the Funersi Director: Aft Natural 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) A. Hussein 686 00 30. Name and address of parson who completed cause of death (Item 23a) (Typa, Print) Frederick MJ 21702 MAAZ A HUSSAN

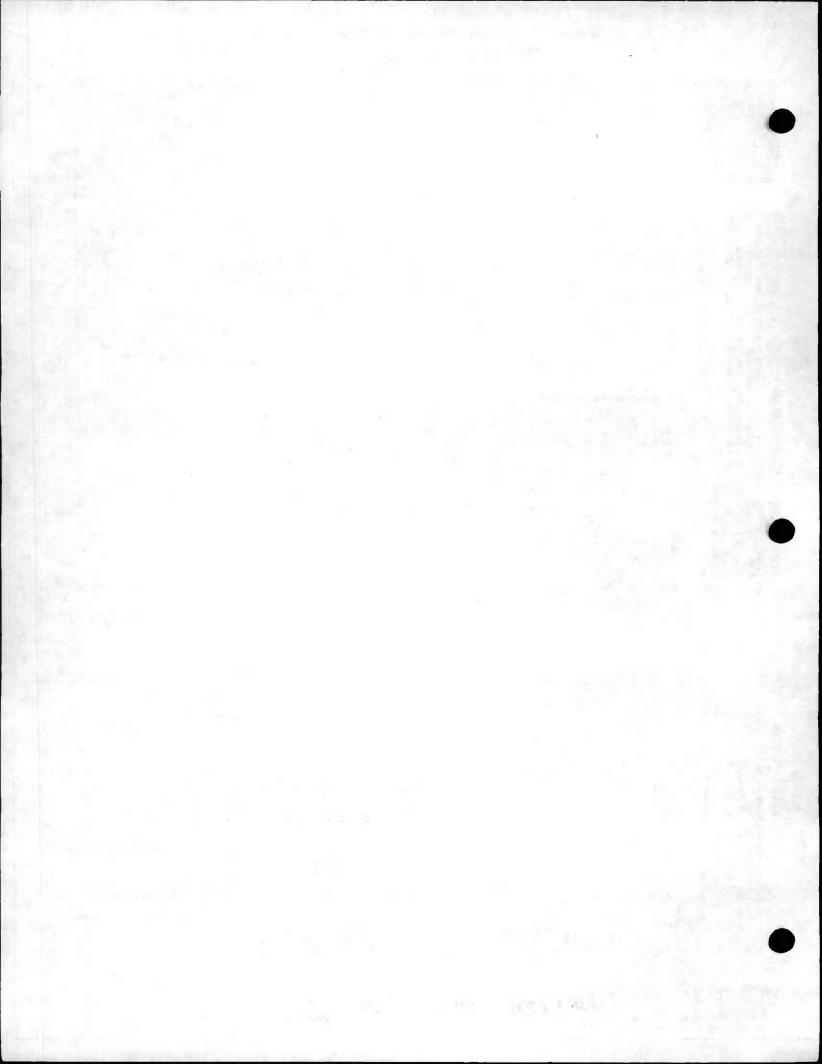
Registrar **DHMH 16 Rev 6/95**

State

31. Date filed (Month, Day, Year)

32. Registrar Signatura

2000



Please Type or Print in Black Indelible Ink. Assure Aii Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death James Victor Shaff, Jr. 19 2000 June 12:15 AM 4b. City, Town, or Location of Death 4a Facility Name (If not Institution, give street end number) 4c. County of Death College View Nursing Center Frederick Frederick 8. Date of Birth (Month, Day, Year) May 31, 1918 5. Social Security Number If Under 1 Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. lest birthday) 1⊠M 2□ F 214-10-1113 Yrs. 82 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits Frederick Maryland Frederick 1 Yes ZNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6050 Elmer Derr Road 21703 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ⊠ Yes 2 □ No 1944If Yes, Give Year or Datas: 1946 14. Race - Amarican Indian, Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2K) Married White 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Saw Mill Operator Building/Lumber 11 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James Victor Shaff Sr Phoebe Stockman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Mrs Ruby P. Shaff/Wife 6050 Elmer Derr Road, Frederick, Maryland 21703 20b. Place of Disposition (Nema of cametery, cremetory or other place) Mt Olivet Cemetery Jun 22,2000 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Keeney & Basford Funeral Home M00706 106 East Chruch Street, Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart ailure. List only one cause on each line. Immediate Cause (Final disease or condition rasulting in death) Due to (or as a consequence of) 10 YR5 MPHYSZMA Due to (or as a consequence of): Dua to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

b

natural, or items 23a

filed within 72 hours after

permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiens. Important: If Isom 27 is mericed other than any injury or other traumetic event the Medium

Saltimore, Maryland 21215-0020

Directo

Funeral

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Completed

Be

Examiner anding physician and usa as the bunal-transit Physician/Medical been signed by the should be detached b Be Completed To the Hospital or Attending Physician: within 24 hours after death.
To the Funeral Director: After this certifica completely filled in by the funeral director; p Certification: To

The law requires that the death certificate be executed

certificata

P.O. Box 68760,

Records,

Division of Vital

Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Part It. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Waturat 5 Pending investigation 2 Accident 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicida

1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

29a. Certifier 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

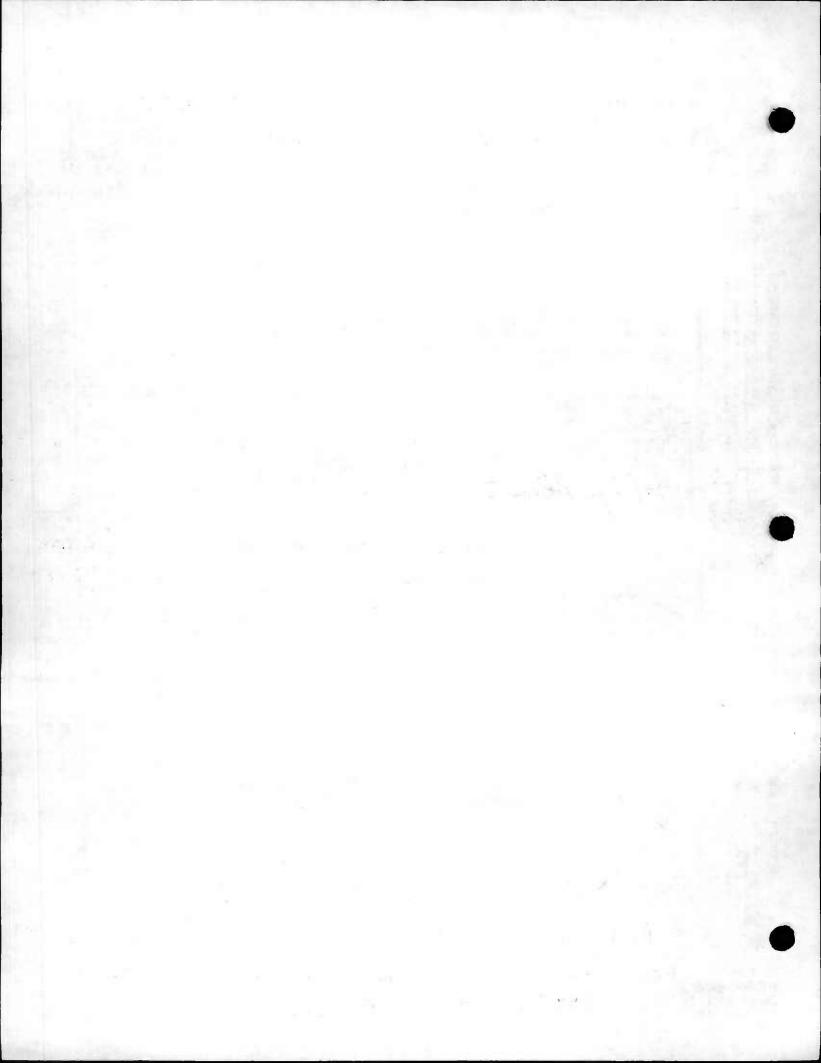
FREDRUCK MD 21702 WARANDERM 1475 MD I-ANEY

State Registrar

DHMH 16 Rev 6/95

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32. Registrage Signature 0 2000



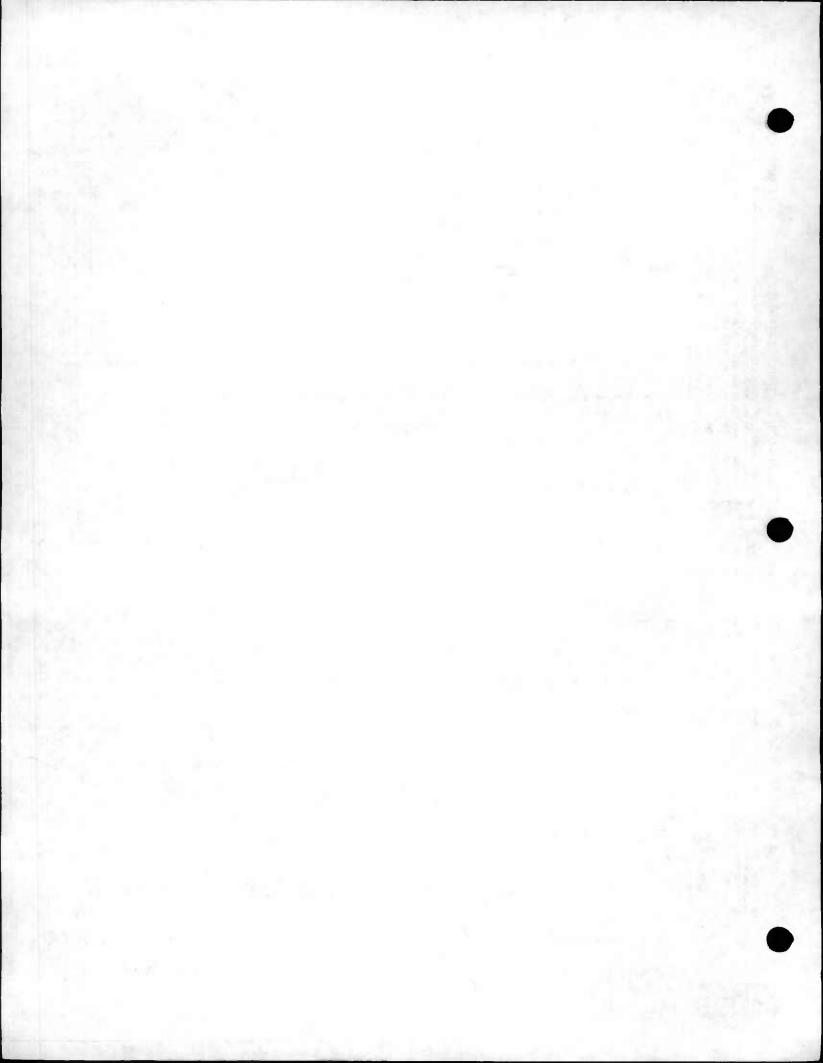
State of Maryland / Department of Health and Mental Hygiene 00 22016

					Certific	cate of	Death		Reg. No.		2010
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within 24 To the Fi	2	Martin C	Days	D			3944			26, 2	
within 24 To the Fi complete	2	29b. Signature and title of certifier 30. Name and address of person wh MARTIN C. SH.				D08	3944	Insington	JUNE	26, 2	

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		State	of Marylar		ertificate of	Health and M Death	- 1	giene [Reg. No.	0	22017
	1. Decedent's Name (First, Midd	le, Last)					2. Date of Dec	eth		3. Time of Death
Physician	Irene Skl	ias					June	23 2	Yeer 2000	9:20 PM
₀/Medical Examiner	4a Facility Name (If not institution	n, give street end n	oumber)			4b. City, Town, or L	ocation of Deeth	4c. County	of Death	
السطا	Montgomery Ge	neral Hos	pital			01ney		Mont	gomer	У
Funeral	5. Social Security Number	6. Sex 1 ☐ M 2 ☑ F	7. Age (In yrs.		Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	y, Year)	9. Birthpl Count	ace (State or Foreign
Director	Usual Residence of Decedent	TOW LAY.	58	Yrs.			Jan. 9,	1942	Greec	e
	10a. State 10b. County		10c. Ci	ity, Town or L	ocation				10	Od. Inside City Limits
ner must be notified at funeral Director	Maryland Montgo	omery	Si	ilver	Spring					1 ☐ Yes 2 No
be notified Directo	10e. Street and Number			On-	10f. Zip Code			10g. Citizen of V	Whet Count	try?
	15329 Durant S	treet			20905	5		USA		
Funeral	11. Merital Status	12. Was De Armed F	cedent Ever In U	J,S. 13.	Was Decedent of I	Hispenic Origin? (Spean, Mexican, Puerto	pecify Yes or No-		e - America	
	1 Never Married 2 Mar	ried 1 Tes	21 No Give		1 ☐ Yes 20 No				. Whit	
d by	3 Widowed 4 Divorced	Year or	Dates:	10.0						
lete	(Specify only highe	nt's Education st grade completed	1)	(Giv	edent's Usual Occu e kind of work done DO NOT use retire	during most of world)	king	16b. Kind of Bi	usiness/ind	ustry
E	Elementary/Secondary (0-12)	College	(1-4or 5+)		Iomemaker			Own	Home	
Be Completed	17. Fether's Name (First, Middle,	Last)				18. Mother's Nam			ne)	Teyr Trings
ToB	Spiros Sakelli	S				Anna H	ajimihal	.is		
	19a. tnformant's Neme/Relations					end Number or Ru				
	Nickolas Sklia	s / Husba				Street, S				
2	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation	3 Removel from	n State	cemetery, cre	osition (Name of emetory or other ple		Date	20c. Location -		
F	4 Donetion 5 Other (S		Un		metery					, Maryland
	21. Signature of Funeral Service	ulaur	~		11800 New	ess of Fecility His Hampshin Oring, Man	re Avenu		erar	nome
	23a. Santi. Enter the disease, o shock, or heart feilure. Light	complications that only one cause on	caused the deal each line.	th. Do not er	nter the mode of dyi	ng, such as cardlac	or respiratory ar	rest,		Approximete Intervel Between Onset and Death
n al	Immediate Cause (Final		ACUTE	- 1	VMPHO	CYTIC	1501	ENIA	1 1	4 chopre
er	disease or condition resulting in deeth)	a		or as a conse		CITIC	CECF		- 1	140012
De			,		,					
Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	6 •	Due to (or as e conse	equence ot):			9	1	
dical	Cause (Disease or Injury that initiated events resulting in death) Last	C	Due to (d	or as a conse	quence of):					
		d.								
lan		-								
Physician/Me	Part II. Other significant condition	ons contributing to	death but not res	sulting in the	underlying cause gi	ven in Part I.				the cause of death?
by Ph	1 300 300						10	res 28 No	3∐ Prob	ebly 4 Unknown
								en eutopsy	24b. We	ere autopsy findings
plet				16 (1)			peno	med?	con	npletion of cause death?
Completed							101	es 20H6		Yes 20 No
Bec	25. Was case referred to medica	1				26. Plece of Dea		101		
ToB	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 20	ER/Outpatie	ent 3 DOA Ot	har	ome 5 Resid		er (Specify	1)
	27. Manner of Death 1 □Naturel 5 □ Pendir		e of Injury onth, Dey Year)	28b. Time Injury	of 28c. Inju	ry at rk?	28d. Describe h	now Injury occur	red	
catl	2 Accident investi	getion not be			M 1	Yes 2□No				
Certification:	4 Homicide determ	nined 286. Plac	ce of Injury - At h ding, etc. (Speci	ome, tarm, s	treet, factory, office		28f. Location (S City or Tox		per or Rura	I Route Number,
	29a. Certifier PCertifyin	ng Physician: To th	a hast of mucha	nuladaa da-	th occurred at the 4	me data and place	and due to the	Augale) and m	onner en ri	etad
edical	(Check only one)	Examiner: On the	basis of my kno basis of examina inner stated.	ation end/or l	nvestigetion, in my	me, dete and place, opinion, death occur	rred at the time,	dete and place,	and due to	the cause(s)
M	29b. Signeture and title of certifie				29c. Licen	se number	- 1 801	29d. Date signe	d (Month, L	Day, Year)
	· Uh	eho	ans		03	3224	-	TUNE	24.	2000
ł	30. Name end eddress of person	who completed cau	use of death (Iter	m 23a) (Type					~ ()	4000
	R. TREHAN	20M	EDMO	DUSTO	on DR	#303	RO	CKULU	LE	20852
State	31. Date filed (Month, Day, Year)		Registrar's Sign	ature 4	las .	4.				
istrar	OUITA	E000 /	4	W.	acount	10				

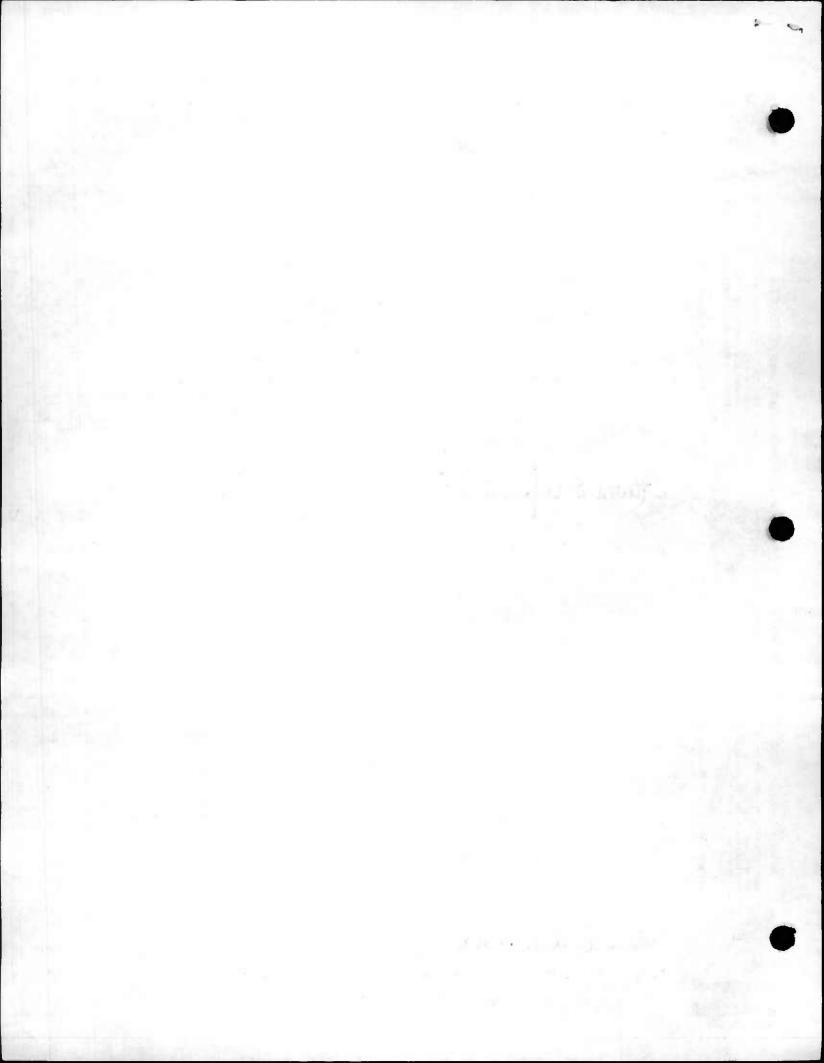
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State of Maryland / Department of Health and Mental Hygiene

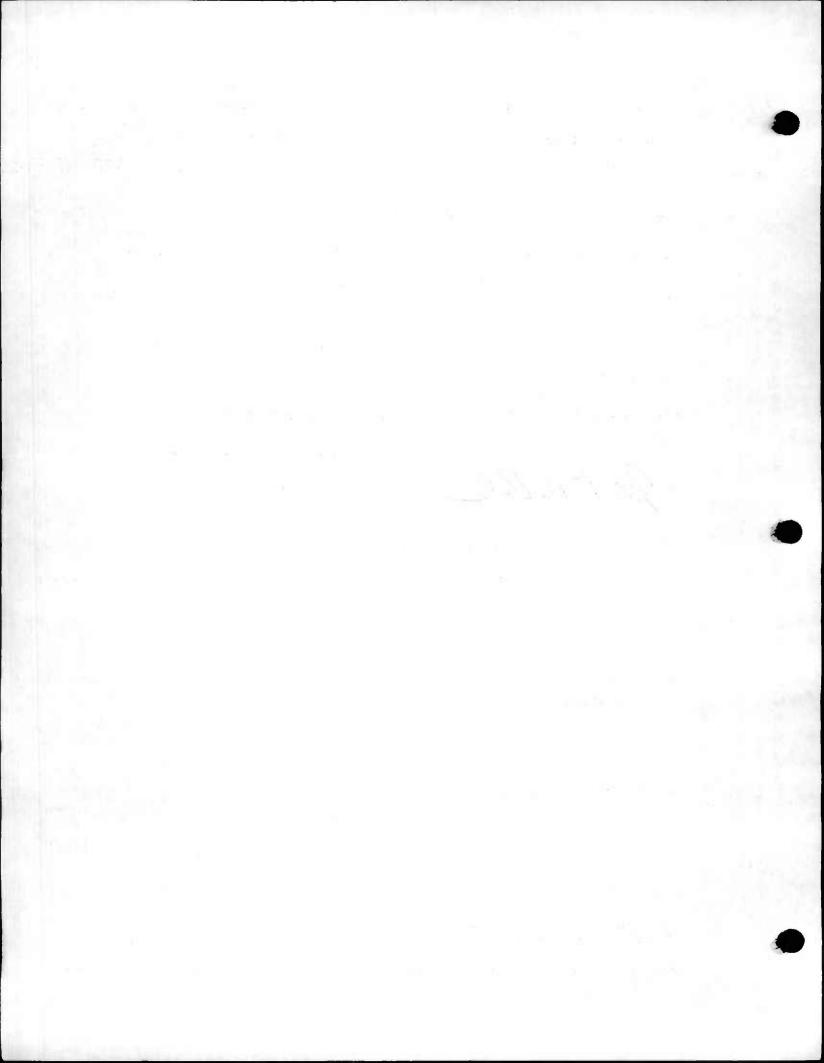
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			Certificate of	Death	Reg. No	a.	C. C. O 1 O .		
	1. Decedent's Name (First, Middle, La	st)			2. Date of Death Month Day Year 3. Time of Death				
Physician /Medical	Patricia	Lee Terr	у			2000	12:30 PM		
Examiner	4a Facility Name (If not institution, given			4b. City, Town, or Loc	cation of Death 4d	. County of Deet	th		
	University of Man	yland	Baltimor	e	None				
Funeral	Social Security Number 6. 9		Months Davs	8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country)					
Director	244-60-1398	1□ M 2□XF 61	Yrs.	Months Days Hours Min. (Month, Day, Year) Super 26, 1938 Country) Virgin					
P	Usual Residence of Decedent 10a, State 10b, County	100 City	Town or Location				40d facida Otha Limita		
eho eho							10d. finside City Limits 1 ☑ Yes 2 ☐ No		
otten otten	MD. None	altimore							
5-0020 72 hours eiter death with the Maryland natural", or items 23s or 28s-7 show deal Exercite must be notified at seted by Funeral Director	10e. Street and Number		10f. Zip Code	10f. Zip Code 10g. Citizen of What Count			ountry?		
ath 123a	1807 West Lafayet			21217			USA o- 14. Race - American Indian.		
of the state of th	11. Marital Status	12. Was Decedent Ever in U, Armed Forces?	S. 13. Was Decedent of I If Yes, specify Cub	13. Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto R		14. Race - Ame Black, White			
o20 urs aft aff. or i	1 Never Married 2 Married	1 ☐ Yes 2 🔀 No If Yes, Give	1 ☐ Yes 2 ☑ No	Specify:	Specify: B		ack		
72 hours natural,	3 ☐ Widowed 4 🛣 Divorced	Year or Dates:							
I 21215-0 ed within 72 ho ygiene. her than "naturn it, the Wedge Completed	15. Decedent's E (Specify only highest gro	ducation ade completed)	16a. Decedent's Usual Occu (Give kind of work done life. DO NOT use retire	pation during most of workin	16b. Kind of Business		Industry		
d 2121 filed within Hygiene. ther then and, in the	Elementary/Secondary (0-12)	College (1-4or 5+)	or 5+)						
d 2 filled 2 filled 2	12 17. Father's Name (First, Middle, Last		Pharmacy As		/First Middle Maider	Pharmacy First, Middle, Maiden Surname)			
and he filed that Hyg ed other event, event,									
aryian should be and Mental and Mental and marked or	Joseph Daniel Ter	*			Sue Jordan				
Baltimore, Marylar permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is merked eny injury or other treumatic engage.	19a. Informant's Name/Relationship (19b. Mailing Address (Street						
m 27	Henry Wagstaff	(Son)	108 Enchanted	l Hills Rd.					
O H To T	20a. Method of Disposition 1XXBurial 2 ☐ Cremation 3 ☐	04	metery, crematory or other pla	ice)	Date 20c. L	20c. Location - City or Town, State			
Part:	4 ☐ Donation 5 ☐ Other (Specif	y) Jet	ers Chapel Cem	netery 6/	/26/00 O1	mega, VA	Α.		
Baltimore, Maryland 21215-0020 semit. Pages 1 and 2 should be filed within 72 hours aft Department of Health and Mental hygiene. Important: If Item 27 is marked other than "natural", or any Injury or other treumatic event, the Marie Earn and. To Be Completed by F	21. Signature of Funeral Service Lice	1seen 2 0	22. Name and Addre	ess of Facility	ropolitan	Funoro	Corvice		
m #9529	Cottinue & 1	1 200.08	5517 Vine	St. Alexa	_		I Selvice		
	23a. Part1. Enter the disease, or comshock, or heart tailure. List only	plications that caused the death	. Do not enfer the mode of dyi	ing, such as cardiac or	respiratory arrest,	. 22510	Approximate		
Physician	SHOCK, OF HEAR CARDINE. LIST ONLY	onapeouse on each line.					Interval Between Onset and Death		
/Medical	Immediate Cause (Final	0 11 4			00 1				
Examiner	disease or condition resulting in death)	a Cardiac Arr		I	20 min				
je de la companya de			as a consequence of):			1	7		
cate be executed physician and the bunaturansit	Sequentially list conditions	b. Wound Sepsi	S as a consequence of):				7 months		
Exe	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	and the same of th							
68760, fficate be exposition to physician as the burial edical Exposition and the control of the	Cause (Disease or Injury that initiated events	c. End Stage R				10 yrs			
OX 66/6U, certificate be executed ding physician and use as the burial-transit Wedical Examin	resulting in death) Last								
leath certifice attending plant of use as t		d_Peripheral	Vascular Disea	ise			10 yrs		
that the death or ed by the attend detached for us	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of cause								
the day	Part II. Other eignincent conditions t	onthouting to death but not resu	23b. Did tobacco use contribute to the cause of death?						
					10 708	1 Yes 2 No 3 Probably 4 Unknown			
HECOTGS, Phe law requires that he has been signed tage 2 should be det ompleted by P					24a. Was an auto	nosv 24b.	Were autopsy findings		
shour should					performed?		available prior to completion of cause		
C) a 20 L							of death?		
= - 50 0					1 ☐ Yes 2	XXNo	1 ☐ Yes 2√ No		
r Vital Mo yelclen: The la s certificate he director, page To Be Com	25. Was case referred to medical examiner?	Hospitali	100	26. Place of Death	(Check only one)				
7 55 50	1 ☐ Yes 2 ☒ No		Produpation: 3L DOA		ne 5 Residence		ocify)		
	27. Manner of Death 1 ⊠ Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of 28c. Inju		8d. Describe how inju	iry occurred			
DIVISION of Attending after death. Director: After d in by the fune.	2 Accident investigation 3 Suicide 6 Could not b								
or Att	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, sfreet, factory, office building, etc. (Specify)			Bf. Location (Street and Number or Rural Route Number, City or Town, State)				
DIVI To the Hospital or Att within 24 hours after of To the Funeral Direct completely filled in by Medical Certifi	29a. Certifier 12 Certifying Ph	ysician: To the best of my know	riedge, death occurred at the ti	ime, date and place, a	nd due to the cause(s	and manner as	s stated.		
the H hin 24 the F mplete	Grey Care	and manner stated.			at the time, date and place, and due to the cause(s)				
To the com	29b. Signature and title of certifier		29c. Licen:	se number	29d. Date signed (Month, Day, Year)				
4	Slain Wash	AM SMA	1245	66	Jui	June 22, 2000			
1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)								
	Blaine Warkentir	ne M.D. 22 So	uth Green Stre	et. Baltin	nore, MD.	21201			
State	31. Date filed (Month, Day, Year)	32. Registrar's Signat	ure o						
Registrar	JUN 262	000 penevar	D. Spork	2					



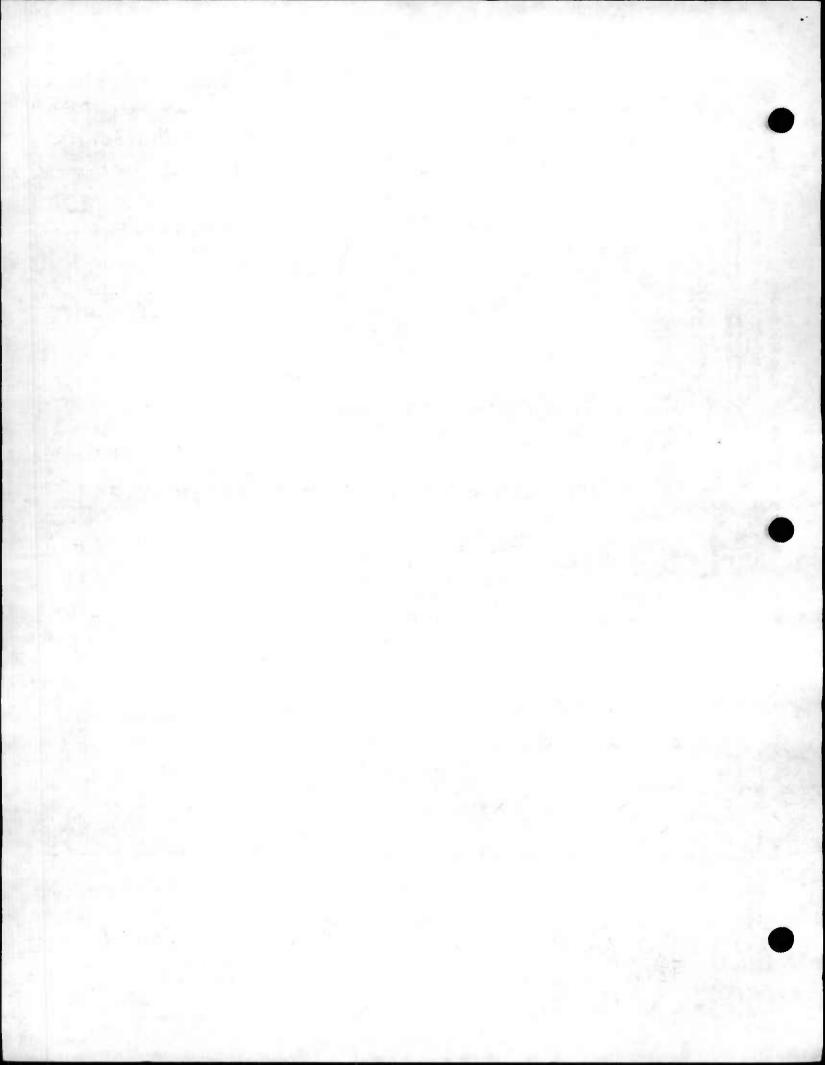
State of Maryland / Department of Health and Mental Hygiene

December Name Prince Name Name Prince Name							Cei	rtificate o	f Death	1		Reg. No.		~ ~ 0 1 3
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Feath Name of Protection Search Search Name of Protection Search Name of			rana	Ξ.	Titus									9:30AM
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Description Director The Second Secondary Numbers of Description The Second Secondary Numbers of Description The Secondary Numbers of Descripti				art H	lome. Inc.				Hyatt	svil	le	Princ	e Geo	roele
Use Part State 100 Control	Fune	eral					st birthdey)		ar if Under	24 Hrs.	8 Date of Bir	th		
Use Part State 100 Control			578-20-2943		1□ M 2KJF	88	Yrs.	Months Dey	s Hours	Min.	03/02/	y, Year) 1912	DC	(try)
Physician //Medical Examiner Due to (or as a consequence of): A cutte Care to row scullar accident a			Usuel Rasidence of Decada	ant							00,02,	-,		
Physician //Medical Examiner Due to (or as a consequence of): A cutte Care to row scullar accident a	ylan	4	10a. State 10b. C	ounty		10c. City,	Town or Lo	cation					1	0d. Inside City Limits
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Physician //Medical Examiner Due to (or as a consequence of): A cutte Care to row scullar accident a	28.		10e. Street end Number									10g. Citizen of	Whet Cour	ntry?
Physician //Medical Examiner Due to (or as a consequence of): A cutte Care to row scullar accident a	Sa or	8 2		3	NT TT			20016						,
Physician //Medical Examiner Dus to (or as a consequence of): Actic Carbonovascular accident 24 Hours decades Dus to (or as a consequence of): Actic Standard Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influe) Dus to (or as a consequence of): Course (Dissas or Influence) Course (Dissas or Influence) Course (Dissas or Influence) Course (Dissas or Influence) Dus to (or as a consequence of): Course (Dissas or Influence) Cou	ris 2		11 Marital Status	oau,		ent Ever in U.S	13 1			lain? (Sn	acity Yas or No			en Indien
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Physician Modical Examinor The property of th	100		23a. Party. Enter the disae	se, or con	plications that cau	sed the deeth.	Do not ent	er the mode of d	lying, such es	cerdlec	or respiretory e	rest,		Approximete
Due to (or es e consequence of): Activity of the standing o	Physici	an	and the standard	LIST OTTY	One couse on ooc	ii jiilo.							1	
Due to (or as a consequence of): Account Section					Δ	. + .	00.	\~ 0 ~ 1 \cdot \			- 0	_		
Due to (or es e consequence of): Second Consequence	Examin	ner	resulting in death)		a	Dun to for	cere	O (O V a 3	ala	ra	cciven	-	1	24 Hews
Due to (or es e consequence of): Second Consequence		į			A								I -	10-10-
Course (Disease of Injury International Last Part of Section 1998) Performed? Performed?	od uted		Coguentially list conditions		b					-			10	recades
Part II. Other algrificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown	D, exec in en	, L	if any, leeding to immadiete			Due to (01 t	as e conseq	dence orj.					I	
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25. Was case referred to medical axeminer? 1	ette for	2		****										
25. Was case referred to medical axeminer? 1	the de	9	Pert II. Other significant co			h but not result	ting in the u	nderlying ceuse	given in Pert	l.	23b. Did t			
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25. Was case referred to medical axeminer? 1	iaw ias b	1 9											010	deeth?
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1 Yes 2 No 1 Inpatiant 2 ER/Outpatiant 3 DOA Other 4 Nursing Home 5 Residence 6 Other (Specify)	ian: ian: ctor.	9	25. Was case referred to fin	edicel					26. Piece	a of Deet	h (Check only o	na)		
State Stat		2	1 Yes 2 No		Hospitel:	atiant 2□E	R/Outpatian	t 3 DOA	Whar /				ner (Specif	v)
29a. Cartifiar (Check only one) 29a. Cartifiar (Check only one) 29b. Signeture and title of certifies 29c. License number 29c. License number 29d. Date signed (Month, Dey, Year) 30 Name end eddress of parson who complated cause of deeth (Itam 23a) (Type, Print) 10 Certifying Physician: To the best of my knowledge, death occurred et the tima, data end plece, end due to the cause(s) end menner es steted. 29b. Signeture and title of certifies 29c. License number 29d. Date signed (Month, Dey, Year)	g P G				28e. Deta of It	njury 2		28c. In		T				<u> </u>
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29a. Cartiflar (Check only one) 29a. Cartiflar (Check only one) 29b. Signeter and title of certifice and menner esteted. 29c. License number 29d. Date signed (Month, Dey, Year) 30 Name end eddress of parson who complated cause of deeth (Itam 23a) (Type, Print) 10 Certifying Physician: To tha best of my knowledga, daath occurred et the tima, data end place, end due to the cause(s) end menner esteted. 29c. License number 29d. Date signed (Month, Dey, Year) 30 Name end eddress of parson who complated cause of deeth (Itam 23a) (Type, Print) 11 Certifying Physician: To tha best of my knowledga, daath occurred et the tima, data end place, end due to the cause(s) end menner es steted. 29c. License number 29d. Date signed (Month, Dey, Year) 30 Name end eddress of parson who complated cause of deeth (Itam 23a) (Type, Print) 12 Certifying Physician: To tha best of my knowledga, daath occurred et the tima, data end place, end due to the cause(s) end menner es steted. 29d. Date signed (Month, Dey, Year) 30 Name end eddress of parson who complated cause of deeth (Itam 23a) (Type, Print) 29c. License number 29d. Date signed (Month, Dey, Year) 31. Determine the tima, data end place, end due to the cause(s) end menner es steted. 29d. Date signed (Month, Dey, Year) 32 Register's Signature	2 4 2 5	1	4 Homicida	/	building,	atc. (Spacify)					City or Tov	m, Stete)		
30. Name end eddress of person who complated cause of deeth (Itam 23a) (Type, Print) Veter M Sch. y Lor MD 7500 Green were Ctr. Dr. Greenbelt Md 20770 State 31. Dete filed (Month, Day, Year) 32. Registrer's Signature	spits nours	1		tifying Ph	nysician: To the be	st of my knowl	edga, daath	occurred et the	tima, data er	nd plece.	end dua to tha	cause(s) end m	enner es si	teted.
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State 31. Dete filed (Month, Day, Year) 32. Registrer's Signature			Kiel	//	111.11	7				TO .				
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UN 8 0 2000 20			21 Date filed (Month Day)					very -	11. 2/		15500	~ [1 - 11	, –	170
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State of Maryland / Department of Health and Mental Hygiene

		C	ertificate of	Death	Re	g. No.	
Physician	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	1	3. Tima of Death
/Medical	ARNOLD J. TRAN	EN			6	24 20	
Examiner	4e Facility Name (If not institution, give street and number) SUBURBAN HOSP		1	4b. City, Town, or Lo SETHESDI If Under 24 Hrs.	4	4c. County of	T6-OMERY
Funeral Director	5. Social Security Number 6. Sex 7. Age (Usual Residence of Decedent	(In yrs. last birthda) 6.7 Yrs.	Months Days	Hours Min.	8. Date of Birth	Year) Wa	B. Birthplace (State or Foreign Country) ashington DC
vith the Meryland or 28a-1 show be notified at Director	MD Montgomery E	Oc. City, Town or Bethesda					10d. Inside City Limits 1√2 Yes 2 □ No
offer death with the Me write mee 23a or 28a-1 s direct meet be notified Funeral Director	10e. Street and Number 4925 Battery Lane		10f. Zip Code 20814			og. Citizen of Wh U.S.A.	at Country?
A L	11. Merital Stetus 1 Never Married 2000 Merried 1 Never Married 2000 Merried 3 Widowed 4 Divorced 12. Was Decedent Ev. Armed Forces? 11 Yes, 20 No If Yes, Give Year or Dates:	er in U,S. 13	3. Was Decedent of H If Yes, specify Cub- 1 Yes 2 No	dispanic Origin? (Spen, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	Black,	American Indian, White, etc. White
iet de le te	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 4	(Giv	cedent's Usuel Occup ve kind of work done . DO NOT use retire	pation during most of work d)	Ing	6b. Kind of Busin	ness/industry
permit. Peges 1 end 2 should be filled within Department of Health and Mentel Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Monte.	17. Fether's Name (First, Middle, Last) Sam Tranen	12210	.602	18. Mother's Name Doria Ba			
and 2 sho alth and 27 is m	19a. Informant's Name/Relationship (Type, Print) Lorna Rae Tranen (Wife)		Battery				ate, Zip Code)
semit. Peges 1 er Sepertment of Hea mportant: If Nem; iny injury or othe	20a. Method of Disposition 15 Burial 2 Cremation 3 Removel from State 4 Donetion 5 Other (Specify)	King Dav	position (Name of rematory or other pla rid Memoria	al Garden	6-24-00	Falls (•
Dependit. Dependit. any inj	21. Signature of Funeral Service Licensee	2 472 N	22. Name and Addre	rea ton St. F	rson Fun alls Chu	eral Hom	1e 22046
Physician	23a. Part1. Enter the disease, or complications that ceused the shock, or heart failure. List only one cause on each line.	e deeth. Do not e	enter the mode of dying	ng, such as cardiac	or respiratory erre	st,	Approximete Interval Between Onset and Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	ue to (or as a cons	sequence of):				6H
executed in end ital-transit	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury	ue to (or as a cons	equence of):				211/
licete be physicials the builded is the builded is the builded in edical	Cause (Disease or injury that initiated events resulting in death) Last	enne E Mi	equence of):	tito			117
death ce	Part II. Other significant conditions contributing to death but r	not resulting in the	underlying cause give	ven in Part I.	23b. Did tol	pacco use conti	ibute to the cause of death?
requires that the death ween signed by the atte hould be detached for etect by Physicia	Dementia, seise	re d	isorde	V	1 □ Ye	2 2 No 3	Probably 4 Unknown
been s should	COPD, CAD		137		24e. Was er perform		24b. Were autopsy findings available prior to completion of ceuse of death?
Physicien: The this certificate had director, page:	25. Was cese referred to medical			20 Division I Division	1□ Ye	s 20 No	1 Yes 2 No
ysician is certifi director	examiner? 1 Yes 2 No Hospital: 1 Impatient	2 ☐ ER/Outpati	ient 3 DOA Oth	nor.	h <i>(Check only</i> one ome 5 ☐ Reside		(Specify)
To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2. Medical Certification: To Be Comp	27. Magner of Death 1 Natural 5 Pending (Month, Day Y	28b. Time	of 28c. Injur	-	28d. Describe ho		
To the Hospital or Attending P within 24 hours after death. To the Funeral Director: After t completely filled in by the funeral Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury building, etc. (- At home, farm, s (Specify)	street, factory, office		28f. Location (Str City or Town		or Rural Route Number,
To the Hospital within 24 hours at To the Funeral Completely filled	29a. Cartifier (Check only one) Certifying Physician: To the best of real Medical Examiner: On the basis of examiner and manner states	kamination and/or i	ath occurred at the til investigation, in my o	ne, date and place, pinion, death occur	and due to the ca red et the time, da	use(s) and mannite and place, an	ner as stated. d due to the cause(s)
To the com	290. Signature and title of conflict Hamme	1	D Licens	8/60	29	d. Date signed ((Month, Day, Year)
	30 Name and address of person who completed cause of deel HAV NER	th (10m 23e) (Type	Beorgt	mm RI	BETH	IESDA	, hD, 20817
State Registrar	31. Date filed (Month, Day, Year) 32. Registrar's	s Signature	2				



State of Maryland / Department of Health and Mental Hygiene 22021 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Death ^{Day} 2000 Month **Physician** Alphonso M. Trapani June 24, 9:15 PM /Medical 4a Facility Neme (Il not institution, give street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Suburban Hospital Bethesda Montgomery If Undar 1 Yaar If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplaca (State or Foreign Country) **Funeral** Days Hours Months 157 M 2□ F 85 Yrs 577-09-7004 Director October 3, 1914 Washington, DC Usual Rasidance of Deceden death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County nam 27 is marked other than "natural", or items 23s or 28s-f show other traumatic avant, the Medical Examiner must be notified as 1 Yas 2 No Maryland Bethesda Director Montgomery 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 20817 8618 Irvington Avenue United States Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) Raca - Amarican Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forcas? 11 Marital Status 2 should be filed within 72 hours after and Mental Hygiene. Is marked other than "natural", or Ne. 1 X Yas 2 No If Yes, Giva Yeer or Detas: 1 ☐ Nevar Married 2 ☐ Married altimore, Maryland 21215-0020 1 Yas 2 No Specify: White WW II þ Specify. 3 X Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) Grocery Store Manager permit. Peges 1 and 2 should be file.
Department of Health end Mental Hy important: If item 27 is merked othe any injury or other territories. 18. Mothar's Nama (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middle, Last) Be Salvatore Trapani Caterina DiMisa 2 19e. Informant's Neme/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael Trapani/Son 109 Ednor Road, Silver Spring, Maryland 20905 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata Data 20e. Method of Disposition 1 X Buriat 2 ☐ Cremation 3 ☐ Removal from State June 28, Gate of Heaven Cemetery 4 Donation 5 Othar (Specify) 2000 Silver Spring, Maryland 22. Nama and Addrass of Facility Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, M00846 7557 Wisconsin Avenue, Bethesda, Maryland 20814-3501 23a. Part1. Enter the disease, or complication that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximata Intarval Batween Onsat and Death **Physician** /Medical Immediate Ceusa (Final 1 Week disaasa or condition rasulting in deeth) Pulmonary Edema Examiner Dua to (or as a consequanca of). Cardiac Failure Examiner 6 Months physician and the burial-trensit certificate be executed Sequentially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting In death) Last Due to (or as a consequanca of): Pulmonary Hypertension Box 68760. 1 Year Physician/Medical Dua to (or as a consequence of): 98 USB Po 23b. Did tobacco use contribute to the cause of death? P.O. the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 2 24b. Wara autopsy findings availebla prior to complation of causa of death? 24a. Was an autopsy performed? Completed Deed certificate has 2 NO 1 ☐ Yes 2 ☐ No 1 Yas 25. Was casa referred to medical axaminar? Be 26. Placa of Daath (Check only one) Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) Hospitel: 10 1 Yes 2N No 1 🕅 Inpatiant 3 DOA 2 ER/Outpatient funeral 27. Mannar of Death 28a. Deta of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: After 5 Panding investigation 1 Neturat death. 1 ☐ Yas 2 ☐ No 2 Accident after death 6 Could not be detarmined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 ☐ Homicida To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, and due to the ceuse(s) end menner es stated.

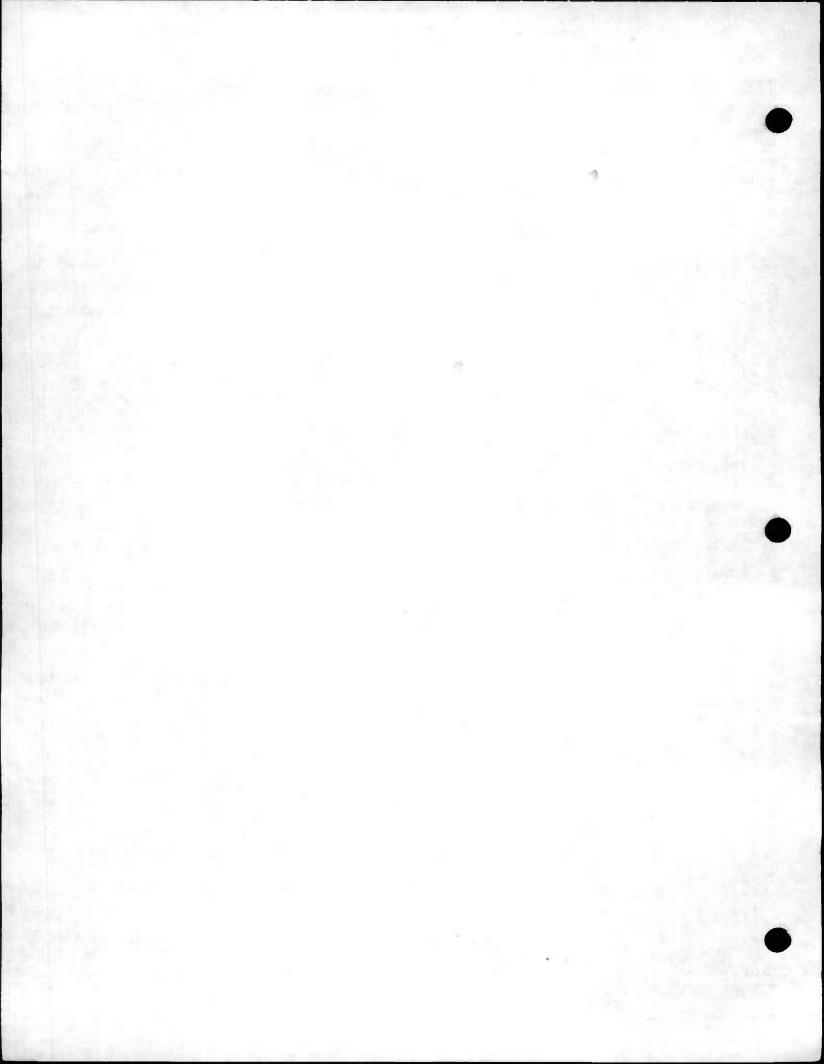
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, data and place, and due to the causa(s) and mannar steted. 29a. Certifier edicai (Check only one) 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and titla of certifiar D05256 June 26, 2000 +1 30. Nama and addrass of person who completed causa of daath (Item 23a) (Type, Print) 30 6000 Executive Blvd., #300, Rockville, Maryland 20852-3803 Lewis N. Cahill, M.D., 31. Date filed (Month, Day, Year) 32. Registrar's Signatura

DHMH 16 Rev 6/95

State

Registrar

JUN 2 8 2000



State of Maryland / Department of Health and Mental Hygiene

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												Reg. No.		
	1. Decedent's Na	1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Day Year											Voor	3. Time of Death
Physician		REH	ENIA		TURNE	BUT.T.					JUNE	0	2000	9:50 P
/Medical Examiner	4a Facility Neme			eet and numb			114	4	b. City, To	wn, or Lo	ocation of Death	_	ty of Death	7.70
LAGITITICS	STI	THOMAS	MORI	E MIRS	ING HO	ME			HYAT	PSVTI	LIE	PE	RINCE	GEORGES
	5. Social Security		6. Sex	ORE NURSING HOME Sex 7. Age (In yrs. last birthdey)) If Unde	r 1 Yeer	If Under	24 Hrs.	8. Date of Birth (Month, Da)			place (State or Forentry)
uneral irector	134-32-	4302	1 🗆 M	4 2)(C) F	87	Yrs.	Months	Days	Hours	Min.	JUNE 4	1913	TOR	TALA, B.
	Usuat Residence	10b. County	-		10c Ci	ty, Town or Le	ocation						1.	10d. Inside City Lin
of all a				-361	100.01									1](1) Yes 2 □
28a-1 notifia	MD.	PRIN	CE GE	EORGES			HYATT	-	LE					
be notified Director	10e. Street and N	lumber					10f. Zij	p Coda				10g. Citizen o	f What Cou	ntry?
	4922	Lasall	LE RI	0				20	782			U.	S.V.I	•
iner must	11. Merital Status	S	12	. Wes Deceda Armed Force		J,S. 13.	Was Dece	edent of H	ent of Hispanic Origin? (Specify Yas or No ify Cuban, Mexican, Puerto Rican, etc.)				ace - Americack, White,	
M. or B		arried 2 Marri		1 ☐ Yes 2 No If Yes, Give 1 ☐ Yes 2 No Specify: Year or Dates:						Spec	ifv:	LACK		
A. the Medical E.		15. Decedent	t's Educat	tion com <i>pleted</i>)	343	16a. Decedent's Usual Occupation (Give kind of work done during most of working					ina	16b. Kind of		
up du		condary (0-12)		College (1-4	or 5+)	lifa.	DO NOT	use ratired	1)					
00	8	3						F	RIVAT	E HOMES				
Be Be	17. Father's Nam	17. Father's Name (First, Middle, Last)				18. Mother's Name					e (First, Middle,	Maiden Suma	ame)	
To B	ANDREW C. FRA					SER				AI	PHENA	T	HOMAS	
	19e. Informant's	Name/Relations	hip (Type		-		ing Addras	s (Street	and Numb	er or Run	al Routa Numbe	or, City or Tow	n, State, Zij	p Code)
17.	MARY	יחיו וופווופו	тт /т	VIICALLE	P_TNL	TATA	2003	O AMI	TER CIT	PD	HVATT	STILE	MD.	20783
E #\\\	MARY TURNBUIL DAUGHTER-IN-IAW 2002 AMHERST RD HYATTSVILLE, MD. 20783 20a. Method of Disposition (Name of Date 20c. Location - City or Town, State													
dus	1 ₺ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete													
	4 Donation 5 Other (Specify) WESTERN CEMETERY 7/8/00 ST. THOMAS, V.I. 21. Signature of Funeral Service Lip@nsee 22. Name and Address of Facility													
	21. Signature of	Funeral Service I	Licensee	1	1	2	2. Name a	nd Addre	ss of Facili	ty				
	19/1	W/B	NM	1.1100	9/		TT A B STOT	ד ספיד	TWEE	AT. HO	3.000 d T3 4	DTV	TACGG	E MD OO
			レンシアトム	レンセヘロロスロ	MOO	091 C	HAME	T Curi			JULS . P. A	A A LALV	DEDAL	ILI a LAID A
	23a. Part1. Enta	r tha disaase, or	complica	tions that ceu	sed the deal						OMES, P. A		ENDAL	Approximate
ololon	23a. Part1. Enta shock, or h	r tha disaase, or aart failura. List	complica only ona	tions that causa on each	sed the deal								ERDAL	Approximate Intarval Between
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22023 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** June 29, 2000 Louis Vagnoni 1:10A. A . /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 3100 Chapel View Drive **Beltsville** Prince George's | H Under 1 Year | H Under 24 Hrs. | 8. Date of Birth | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (State or Foreign (Month) Day, Year) | 9. Birthplace (5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** XXM 2DF 579-20-9510 77 Yrs. Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's Beltsville 1 ☐ Yes 2 XNo Director 28a-f 10a. Street and Number 10f. Zip Code 10g. Citizen of Whal Country? 8 must be 3100 Chapel View Drive 20705 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours aher Department of Health and Mental Hyghens. Important: It item 27 is marked other than "natural", or its any follury or other trearmeds event, the Medical Examiner Armed Forces?

XXYes 2 No
If Yes, Give
Year or Dates: WWII 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 200 No Specify: White Specify: ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Personnel Officer United States Navy 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Orazio Vagnoni Carmela Capone 2 19a. intormant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Martha B. Vagnoni (wife) same as #10 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 □ Cremation 3 □ Removal from State Fort Lincoln Cemetery 7/3/2000 Brentwood, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donald v. Borgwardt Funeral Home, P.A. 21. Signature of Funeral Service Licens 4400 Powder Mill Rd. Beltsville, Maryland 20705 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a CARCINOMA Examiner Due to (or as a consequence of): Physician/Medical Examiner METASTSIS BRAIN attending physician end for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Ceuse (Disease or injury Dua to (or as a consequenca of) P.O. Box 68760. that initiated events resulting in death) Last Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULHONARY DISEASE Division of Vital Records, à 8 director, page 2 should Be Completed 24b. Were eutopsy findings available prior to 24a. Was an autopsy completion of cause of death? this certificate hes 1 ☐ Yes 2XXIVo 1 ☐ Yes XX No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; E 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 NesIdence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how Injury occurred Vetural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide **Exertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

15

31. Date filed (Month, Day, Year)

ILIN 3 0 2000

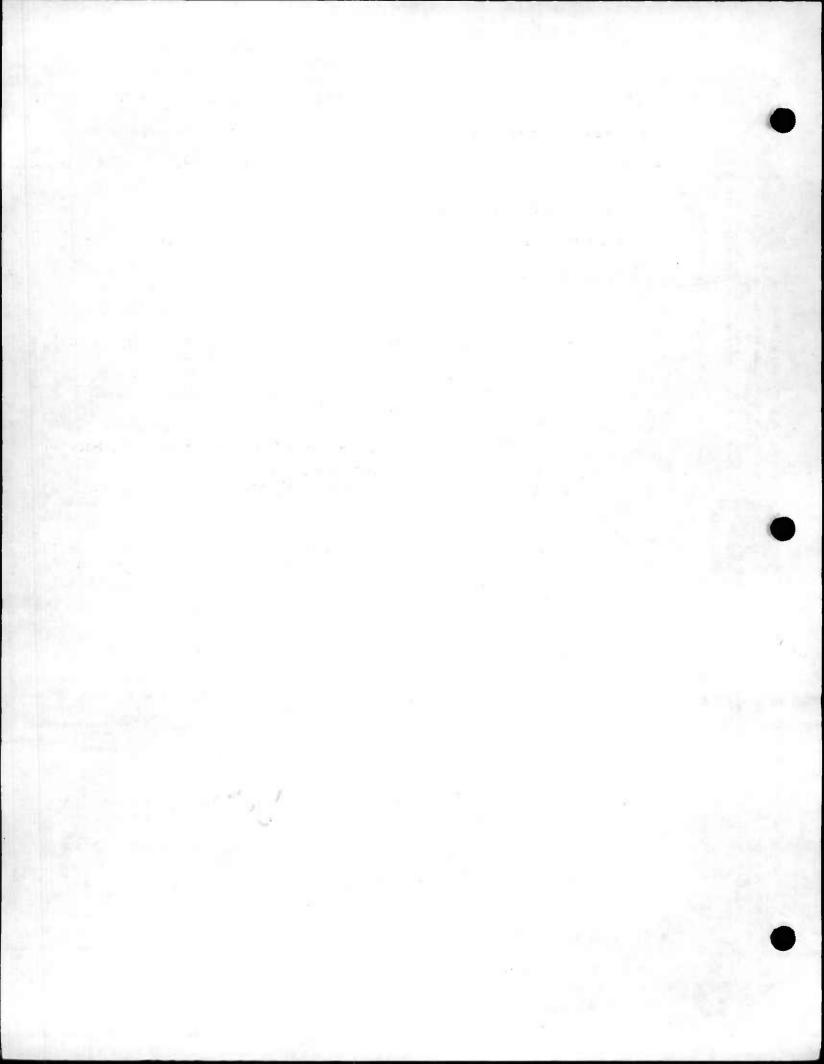
30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

Azher Hussain, M.D. 4917 Edgewood Road College Park, Maryland 20740

Do0/3668

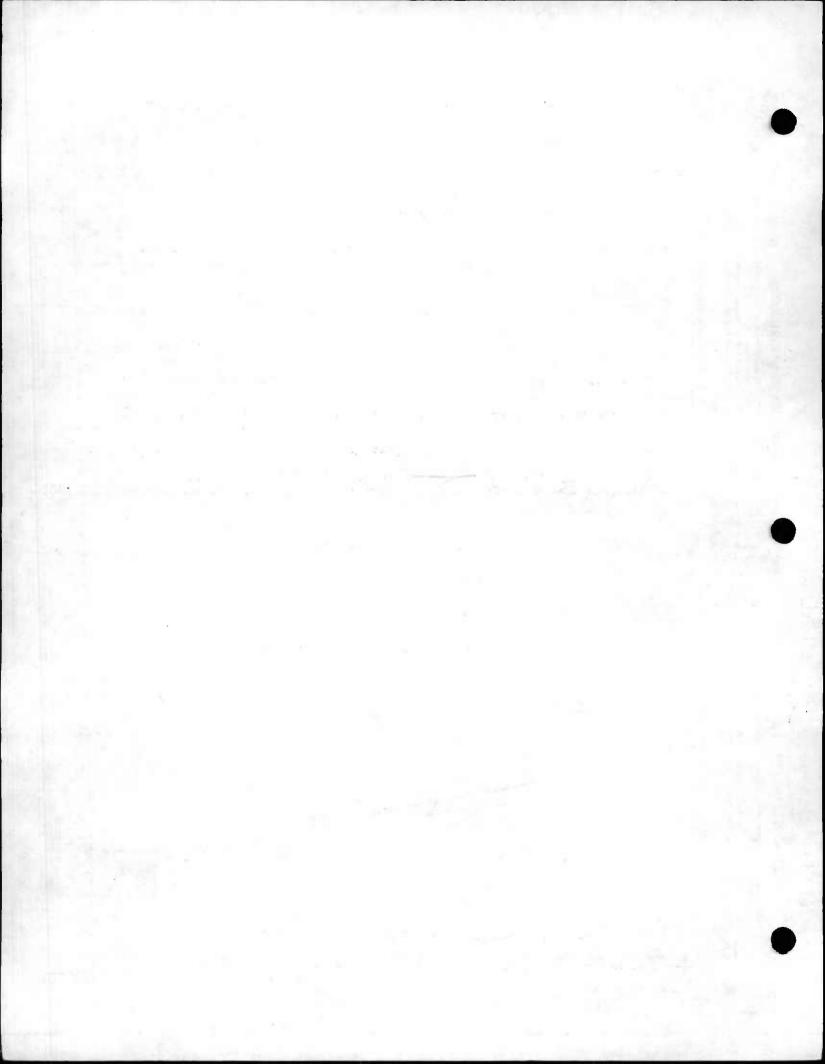
June 29, 2000



State of Maryland / Department of Health and Mental Hygiene

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14.14	Funeral	5. Social Security Nu	mber 6. S	Sex	9x 7. Age (In yrs. last birthday)			1 Year	If Under	24 Hrs.	8. Date of Bir (Month, De			plece (Stete or Foreign
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	anylan ahow adat	10a. Stete	10b. County		10c. Cit	y, Town or Lo	or Location						1	Od. Inside City Limits
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	ther destit with the Maryla r terms 23e or 28e-1 sho siner must be notified at Funeral Director	11. Meritel Stetus	Cona Doi	12. Wes Dece	dent Ever in U	S. 13. V	13. Was Decedent of Hispanic Origin? (Spi			cify Yes or No		ce - Americ	can Indien,	
Baltimore, Maryland 21215-0020	E 25 F	1 ☐ Never Merrie 3 ☑ Widowed 4	_	Armed For 1 Yes If Yes, Giv Year or De	2 (X) No	If Yes, specify Cuban, Mexican, Puerto Rica 1 ☐ Yes 2 ☒ No Specify:				Rican, etc.)	Specif	ck, White, y: Whi		
2	72 hours natural, dical Exa		15. Decedent'e E			16a. Deced	ent's Usua	I Occup	ation			16b. Kind of B	usiness/in	dustry
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P	be file d othe event,	17. Father's Neme (F	irst, Middle, Last,)					18. Mothe	r's Neme	(First, Middle	, Maiden Sumei	ne)	
a	o senta	Walter D. Soles Elizabeth Ross												
2	Shou man		19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State								. State. Zic	Code)		
ž	Pages 1 and 2 should be filled with ment of Health and Mental Hygles tant: if Item 27 is marked other to jury or other treumetic event, the Jury or other treumetic events and the Jury of the Jur	Colleen McLachlen (Daughter) 10 Sausilito Court Annapoli												
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章	mit. Page partment of containt: If I cinjury or de.	4 Donetion 5 Other (Specify) Rock Creek Cemetery 06/27 Washington, 21. Signeture of Funeral Service Licensee 22. Name and Address of Fecility									DC			
gal	Balt permit. Cepartri Imports any inits	21. Signeture of Fun	eral Service Licer	nsee	1	22	OSEPI	d Addre	ss of Fecilit	y S SOI	NS, INC	1.		
		Sugar	ery B.	Lue	ha								ton,	DC 20016
		23a. Pert1. Enter the shock, or head	discuss, or com	plications that co	aused the deat								- 1	Approximete Interval Between
1	Physician /Medical Examiner	Immediate Cause (Finel disease or condition resulting In deeth) Hypoglycemic Encephalopathy Due to (or es a consequence of): Diabetes Mellitus												
5	pen pu	Commented to the second		b. Diab										
Am 68760,	finate be executed as the burishment extra Examiner	Sequentially list conditions, if erry, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events Due to (or as a consequence of): Hypertension Enter Underlying Cause (Disease or Injury that Initiated events)												
47.77 80 x 68	ding p	resulting in death) La	Due to (or as a consequence of): Chronic Obstructive Pulmonary Disease											
-0-m	d for allo	Pert II. Other algnific	ant conditions o	ontribution to do	ath hut not soon	diam in the co			on in Dord I		1 22h DI4	tabaaa		o the cause of death
0	at the death of by the atten- stached for ur	Total Culor algunic	ant conditions o	Orthodring to de	atti but not 1654	atting in the or	idenying G	ause giv	en in reit i.			- 12		more and a second
2年二											,,,	Yes 25 No	3 PIO	bably 4 Unknow
de En	ulres ti signe id be d by										24a Was	en eutopsy	24b. W	ere eutopsy findings
300	The law requirements page 2 should										perfo	med?	ev cc	railable prior to empletion of cause
الم المرا	has pe 2 :												of	deeth?
2 7 E	ificate h. or, page										10	Yes 2X No	1 [Yes 2 No
Vita	Physician: The rai director, page To Be Co	25. Wes case referre axeminer?	d to medical							of Deeth	(Check only o	one)		
Time of Vital	hysic this c ai dire	1 ☐ Yes 2 🛣 N	0	Hospitel: 1 🔀 li	npatient 2	ER/Outpatien	3□ DO	A Oth	er: 4 Nu	rsing Hon	ne 5□Resi	dence 6 Oti	ner (Specil	y)
THO	ng P fler ti nnera on:	27. Menner of Death 1 X Neturel	5 Pending	28a. Dete d (Mont)	f Injury h, Day Year)	28b. Time of Injury	2	8c. Injun Wor	y et k?	2	8d. Describe	how Injury occu	rred	
5/00 Division	Attending in death. Sctor: After by the fune filecation	2 Accident	investigation				М	1 🗆	Yes 2 1	Vo				
5/00 Division	r Attentier deat rector: by the	3 Suicide 4 Homlcide determined 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Str. City or Town,								Street end Num	treet end Number or Rurel Route Number,			
	Division To the Hospital or Attending P within 24 hours after death. To the Funeral Director: Aftert completely filled in by the funer Medical Certification:	4 Homicide building, etc. (Specify) City or Town, Stete)												
7/9		29a. Certifier (Check only one) Constitution: Con												
A		29b. Signature end til						. Licens	e number			29d. Dete signe	ed (Month,	Day, Year)
	/	m. a	ende n	1. Tho	mpson	MS) -	D4	402	5		61	23/	00
	15	30. Neme and address	is of person who	completed cause	of death (Item	23a) (Type, I	Print) 125	R	DCKV	ille	Pike	, Ro	CKVII	10.
	0	31. Date filed (Month)	Dev. Year)		gistrar's Signa				> 0/1	E- 1	43	/-		
	State Registrar		JN 2 6 20		Lyenas orgina	19.	ppo	uls						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month June 26, 2000 12:55 am Elbert Leon Virts 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Olney Montgomery General Hospital Montgomery If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (Stata or Foraign Country) 11XM 2□ F Vrs Dec 30, 1918 213-16-2579 Virginia Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yes 2 No Maryland | Montgomery Silver Spring 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? 15115 Interlachen Dr. Apt 207 20906 USA 12. Was Decadent Ever in U,S. Armed Forces? 13. Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Raca - American Indian Black, White, etc. 1 XYes 2 No tf Yas, Give Year or Dates: 1 Never Married 2 Married 1944 1945 1 Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade complated) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) John Hopkins Applied Flamantary/Secondary (0-12) College (1-4or 5+) Purchasing Supervisor Physics Lab 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Elbert Joseph Virts Lela C. Smith 19b. Mailing Addrass (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15115 Interlachen Dr., Apt 207, Silver Spring, MD Vivian Virts / Wife 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/29/00 Silver Spring, MD Gate of Heaven Cemetery 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Part1. Entar tha disaasa, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or haart failura. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition rasulting in death) NOW SMAL CELL LUNG Comu Due to (or as a consequenca of) Due to (or as e consequença of) 23b. Did tobecco use contribute to the cause of deeth? 3 Probably 4 Unknown 1 Yes 2 No 24a. Was an autopsy

Physician /Medical Examiner

cartificate be axecuted

P.O. Box 68760.

Division of Vital Records.

Physician

/Medical

Examiner

Funeral

Director

ral', or items 23s or 28s-f show Examiner must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours aftar c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or item any injury or other traumetic event, the Medical Entit har once.

Saltimore, Maryland 21215-0020

Directo

Funeral

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Examiner attending physician and I for usa as tha bunal-transit Physician/Medical signed by the s p ate has been signated bage 2 should b Completed s cartificate has director, page 2 Be 2 Certification: To the Hospital or Attendi within 24 hours after death To the Funeral Director: A complately filled in by tha f

Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Causa (Diseasa or Injury that initiated evants resulting in death) Last

Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I.

24b. Were autopsy findings eveilebie prior to completion of ceuse of daath?

1 Yes

26. Place of Death (Check only one)

25.	Was casa rafe	rred to	medical
	1 ☐ Yes 2	No	
27	Manner of Dag	th	

3 Suicide

29a. Cartifier

4 Homicida

1 Alatural 5 Pending Investigation 2 Accident

Inpatient 6 Could not be determined 28e. Placa of Injury - At home, farm, streat, factory, office building, efc. (Specify)

Hospital

2 ER/Outpatient 3 DOA 28b. Time of Injury

Othar: 4 Nursing Home 5 Residence 8 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

28d. Describe how injury occurred 28f. Location (Street and Number or Rurel Route Number, City or Town, State)

Certifying Physicien: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.

2 Medical Exeminer: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DUNEY.

29b. Signature and title of certifian

29c. License number

29d. Date signed (Month, Day, Year)

55805

30. Neme end add ess of person who completed cause of death (Item 23a) (Type, Print) Philip 13111 Prina

KARIM Joseph 31. Date filed (Month, Day, Year)

JUN 2 9 2000

32. Registrar's Signature

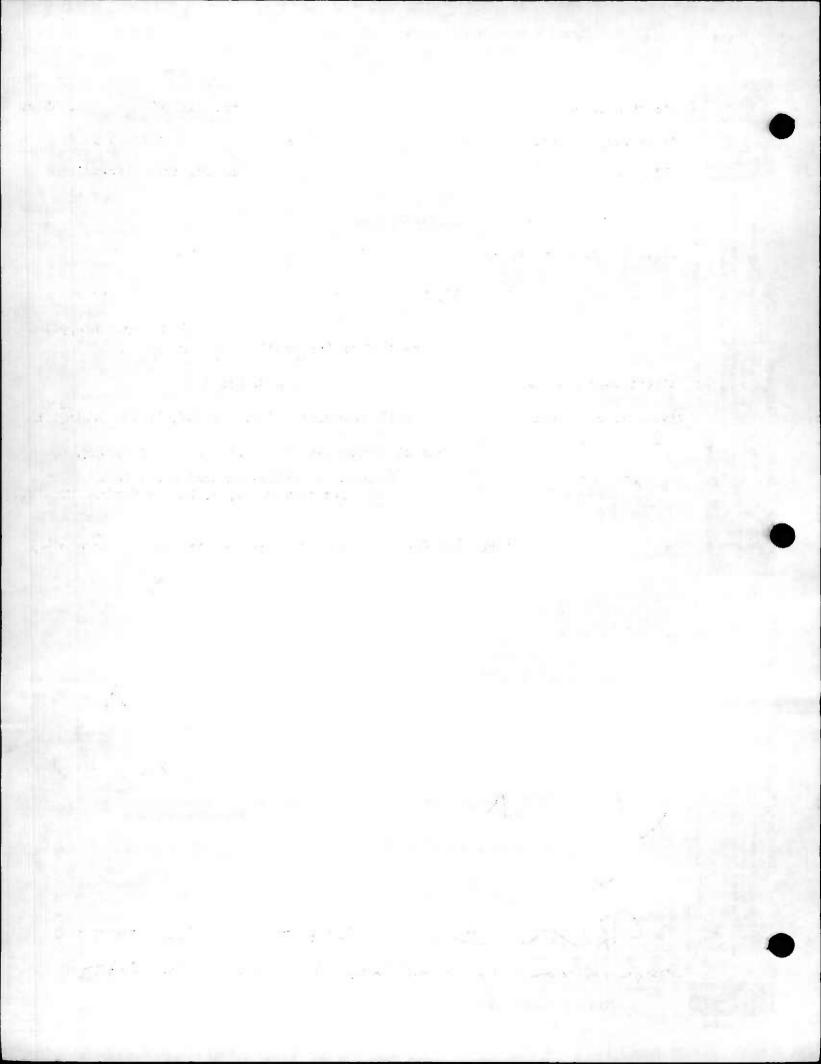
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State Registrar

Medicai

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death.



State of Maryland / Department of Health and Mental Hygiene 22026 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day **Physician** Month James Richard Wagner, Sr. 22, 2000 June 1347 /Medicai 4a. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Dorchester General Hospital Cambridge Dorchester 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Feb 1,1926 Birthplace (State or Foreign Country)
Maryland 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** MOM 20 F Days 216-22-9328 Yrs. Director 74 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Itema 23s or 23s-f show any Injury or other traumatic event, me Medical Examiner must be notified anone. 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Carroll Westminster 1 ☐ Yes 2 🖾 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2559 Albert Rill Road 21157 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian. Black, White, etc. the Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 XMarried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: WII Specify White by 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Home Building Carpenter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Marshall C. Wagner Georgia V. Rupp 2 19a. Informant's Name/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carrie Wagner, wife 2559 Albert Rill Rd, Westminster, MD 21157 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State ₩ Buriai 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Wesley Cemetery 6/25 Hampstead, MD 21. Signature of Fameral Service Licenses 22. Name and Address of Fecility Eline Funeral Home M00723 934 South Main St, Hampstead, MD 21074 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate tnterval Between Onset and Death Physician Immediate Cause (Finel disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner The law requires that the death certificate be executed ettending physician and for use as the bunal-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury Division of Vital Records, P.O. Box 68760, that initiated events resulting in death) Last Due to (or as a consequence of). certificate has been signed by the riector, pega 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 3 Probably A Unknown 1 ☐ Yss 2 ☐ No ģ 24b. Were autopsy findings eveileble prior to completion of cause of death? Completed 24e. Wes an autopsy 2 2 No 1 Yes 1 Yes 2 No or Attending Physician: the funeral director, Be 25. Was cese referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ROUTPatient 3 DOA 2 TES 2 No 1 Inpatient After this 27. Manner of Death 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 15 Natural s eftar death. 1 Yes 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 4 \(\text{Homicide} \) To the Hospital o within 24 hours ef To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the ceuse(s) end manner as stated.

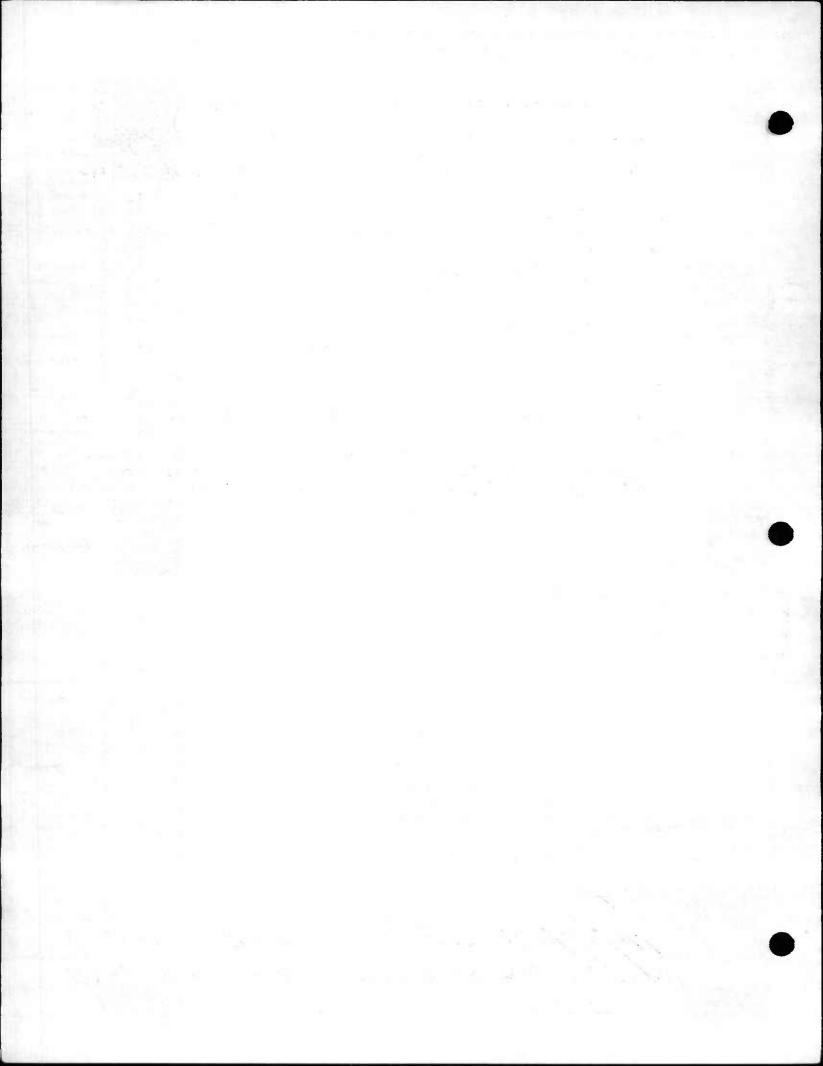
The dieaf Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and menner stated. 29e. Certifier Medicai (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

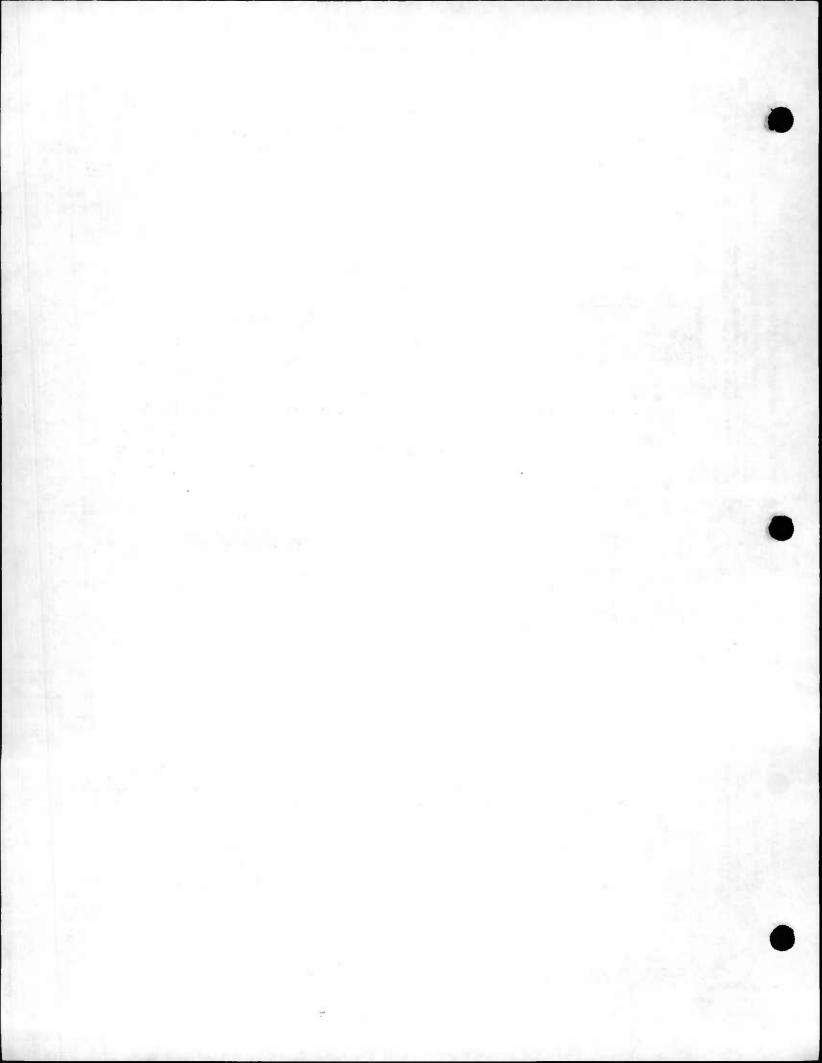
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Hurlock MD 21643



		State o	f Maryland / I	Departmer Certificat			nd Mer		iene () () 2	2027
	1. Decedent's Name (First, Middl	e, Last)	A 12				2.	Dete of Death	1		3. Time of Death
Physician /Medical	Arthur N	William '	Weaver				J	Month une 2	2, 200	Year 00	12:50 am
Examiner	4a Facility Name (If not institution	n, give street and nur	nber)		4	b. City, Tov	vn, or Locati		4c. County		1
	Long View N		ome Manches							rroll	
Funeral Director	5. Social Security Number 213-03-0639	6. Sex 1⊠ M 2□ F	7. Age (In yrs. last bi	Yrs. If Under	1 Year Days	If Under 2 Hours	f Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State Country) Mar 16,1917 Maryland				
and **	Usual Residence of Decedent 10a. State 10b. County		10c. City, Tow	n or Location	-	-				11	0d. Inside City Limits
Mery	Maryland Car	roll			H	lampst	cead				1 ☐ Yes 2 ☑ No
ter death with the Merylar ter death with the Merylar them 23e or 28e-f show fret must be notified at Tuneral Director		renue		10f. Zip	Code	2107	74	10	og. Citizen of W		itry?
1215-0020 within 72 hours efter death with the Meryland ene. then "natural", or items 23s or 28s-f show the Medical Examinat must be notified at sympleted by Funeral Director	3 ☑ Widowed 4 ☐ Divorced	Armed Fo	2 🔀 No	13. Was Dece If Yes, spe			in? (Specify , Puerto Rica	Yes or No- an, etc.)		- Amarica k, White, o	
Maryland 21215-0020 to 2 should be filed within 72 hours eft thin and Mentel Hygiene. The marked other than "natural", or traumatic event, or Medical Exercitivaments avent, or Medical Exercitivaments.	15. Deceden (Specify only higher Elementary/Secondary (0-12)			Decedent's Usu (Give kind of wo life, DO NOT u	al Occupa irk done d se retired; Datch	luring most)	of working		Baltin Gas &	nore	tric Co
yland 2 build be filled Mental Hygianted other etic event, II	17. Father's Nama (First, Middla,						r's Name (Fi La Eba		laiden Sumam	e)	
	19a. Informant's Name/Relations Bonnie Greenho			Malling Address 3927 SI							Code)
Ores of the state	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		State cemete	of Disposition (New lary, crematory or Co DSTEAD CO	ther place		6/		Hampst		
Baltim, Peg Dermit. Peg Department important: If any Injury o ance.	21. Signeture of Funeral Service Licensee N0023 22. Name and Address of Facility Eline Funeral 934 South Main St, Hampstead, I										74
Physician /Medical Examiner	23a. Part1. Enter the disease, or shock, or heart feilure. List Immediate Ceuse (Final disease or condition resulting in death)	complications that complications that complete comp	Chronic	old strains							Approximete Interval Between Onset and Death
death certificate be executed e attending physician and sof for use as the buriel-transit sician/Medical Examiner	Cause (Disease or Injury that initiated events resulting In death) Last	b		consequence of):				2			
Box eath cert attendin d for use	Day II Ohbaratan III and a state										
P.O.	Part II. Other significant condition		ath but not rasulting i		ause give	en in Part t.				3 Prot	the cause of death? pably 425Unknown
ew requires sa been so 2 should				/				24a. Was ar perform	n autopsy ned?	ava	ere autopsy findings allable prior to mpletion of cause death?
Corr								1 □ Ye	s 25 No	1	Yas 2□ No
of Vital Re Physician: The I this certificate he ral director, page	25. Was case referred to medical examiner?	Hospital:			Othe			heck only one			
Physic rithis of rail direction of T.	1 ☐ Yes 2 ☐ No 27. Manner of Death	1 □ Ir	npatient 2 ER/Ou		JA	4 IZ>(\VUI	-		nce 8 Other		y)
Division of To the Hospital or Attending Phywithin 24 hours after deeth. To the Funeral Director: After this completely filled in by the funeral Medical Certification: 7	1 Netural 5 Pendin 2 Accident investig 3 Suicide 6 Could r 4 Homicide	g (Monti petion not be ined 28a. Placa		M		? /es 2□N	10		reet and Numb		I Route Number,
To the Hospital or within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Certifier (Check only (Ch										
thin 2, the F mplet	one)	and mann									
ST S	29b. Signature and title of cartifier			29c. License number					29d. Date signed (Month, Day, Yea		
	30. Name and address of person		1 41 1			757°		0 717		27,	(000
01-1	31. Date filed (Month, Day, Year)		de Hegyts		1-70	11100	M	2 -512	o≤		
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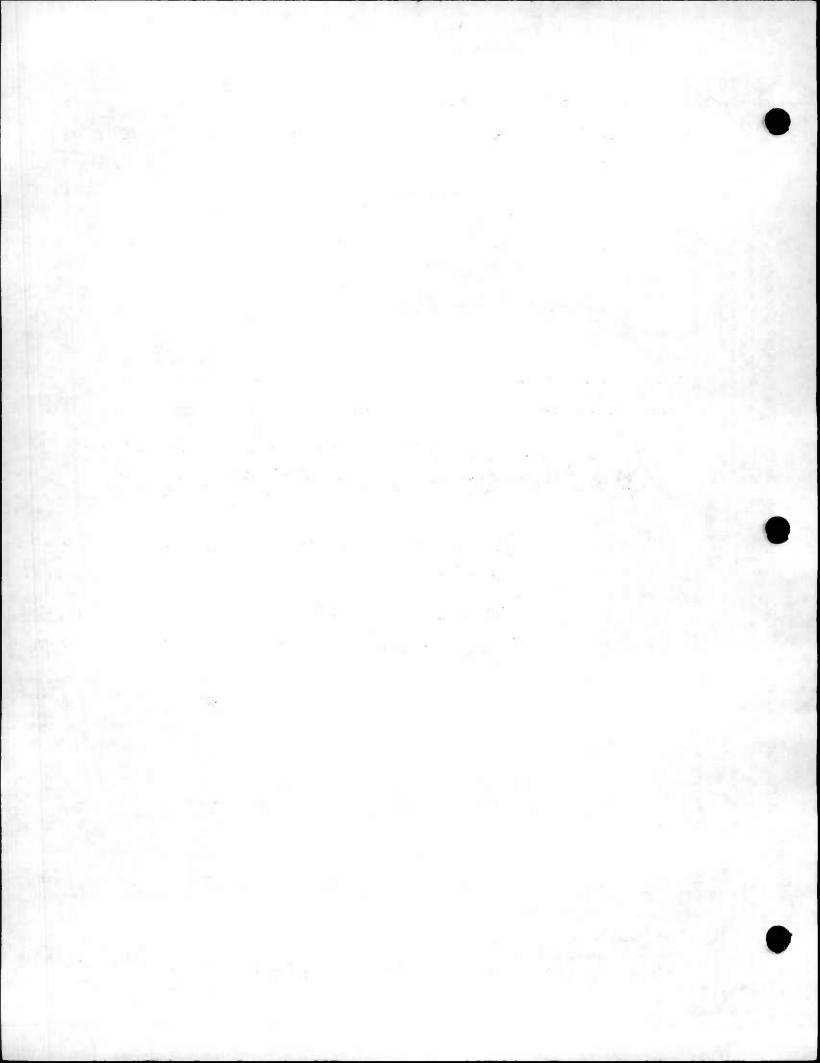


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** MYRTI F VIRGINIA WINDSOR JUNE 28, 2000 4:50 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 15620 ST. THOMAS CHURCH ROAD UPPER MARLBORO PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) NOV. 1, 1921 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days MARYLAND 218-24-0495 Yrs. Director 78 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or itema 23s or 28s-f show traumatic event, the Medical Examinar must be notified at 1 ☐ Yes X☐ No Upper Marlboro Prince George's Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20772 U.S.A. 15620 St. Thomas Church Road Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 🐧 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or then any injury or other traumatic event, are Medical Conte Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Yes, Give à 3 N Widowed 4 □ Divorced WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John Francis Thomas Martha Ann Beatly 19a. Informent's Name attonship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ronnie E / Windsor/Son 15620 St. Thomas Church Rd., Upper Marlboro, MD 20772 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of D Date 20c. Location - City or Town, Stete 1 X Buriel 2 Cremetion 3 Removal from State 07-03-2000 Croom, Maryland Thomas Cemetery 5 Other (Specify) THE HUNTT FUNERAL HOME, INC. MARK G. M00053 BROHAWN P.O.BOX 156, WALDORF, MARYLAND 23a. Part1. Unter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate interval Between Onset and Deeth **Physician** Immediate Cause (Finel disease or condition resulting in deeth) /Medical civuhosis. 8 months ecom bewsated Examiner Due to (or es a consequence of): Physician/Medical Examiner Ascites attending physicien and for use as the burial-trensit The law requires that the deeth certificete be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated expenses.) ucephalopatu P.O. Box 68760. that initiated events resulting in death) Last monery Part II. Other signifficant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifica stely filled in by the funeral director, p Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 D Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in Tertifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year) 29c. License number 0420 JUNE 29, 2000 Upper Marlboro Md. 20772 who completed cause of death (Item 23a) (Type, Print) Alain. HAMPALOUX шb. 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22029 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death June 23, William Francis Wooten 2000 **Physician** 11:30 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) **Examiner** 11506 Accolade Terrace Prince George's Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Sept. 6, 1925 5. Social Security Number 6 Sax 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) **Funeral** Days Hours 1 M 2□ F 402-22-4489 74 Yrs. Kentucky Director Usuel Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hyglene. Importants if Item 27 is marked other than "natural", or items 23a or 28a-f ahow with lighty or other traumatic event, the Medical Examples must be notified at ones. 10a. Stete 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 ☐ Yes 2/☐ No MD Director P.G. Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11506 Accolade Terrace 21213 USA Completed by Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 1 △ Yes 2 ☐ No 14. Race - American Indian 11. Merifal Stetus Bleck, White, etc. 1 ☐ Never Merried 2 ☐ Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify. 3 Widowed 4 □ Divorced Black 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) College (1-4or 5+) Letter Carrier U.S. Postal Service 12 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be George Nelson Wooten Cleo Boone 19e. tnforment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Larry Wooten - Son 11506 Accolade Terrace Clinton, MD 21213 20b. Plece of Disposition (Name of cemetery, cremetory or other plece, 20e. Method of Disposition 20c. Location - City or Town, Stefe 1 XBuriat 2 Cremetion 3 Removel from Stete Calvary Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 6-26-2000 Shelby ville, KY 21. Signature of Funerel Servica Licensee 22. Neme end Address of Facility Metropolitan Funeral Service, Inc. 5517 Vine Street Alexandria, VA 22310 23 Pert 7. Enter the disease, of complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Deeth **Physician** Immediete Ceuse (Final disease or condition resulting in deeth) /Medical Examiner Due to (or as e consequence of) Physician/Medical Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or es e consequence of): Box 68760 thet initieted events resulting in death) Last Due to (or es e consequence of): P.O. I is signed by the ail Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco uas contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XUnknown MELLITUS Records. Be Completed by 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes an eutopsy 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 1 Yes 2 No edical Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 28a. Dete of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homloide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner steted. 29a, Certifier LOUS V. KAUFMAN, MAZOC. License number 29b. Signeture and fitte of certifier 29d. Date signed (Month, Day, Year)

20

State Registrar

31. Dete filed (Month, Dey, Year)

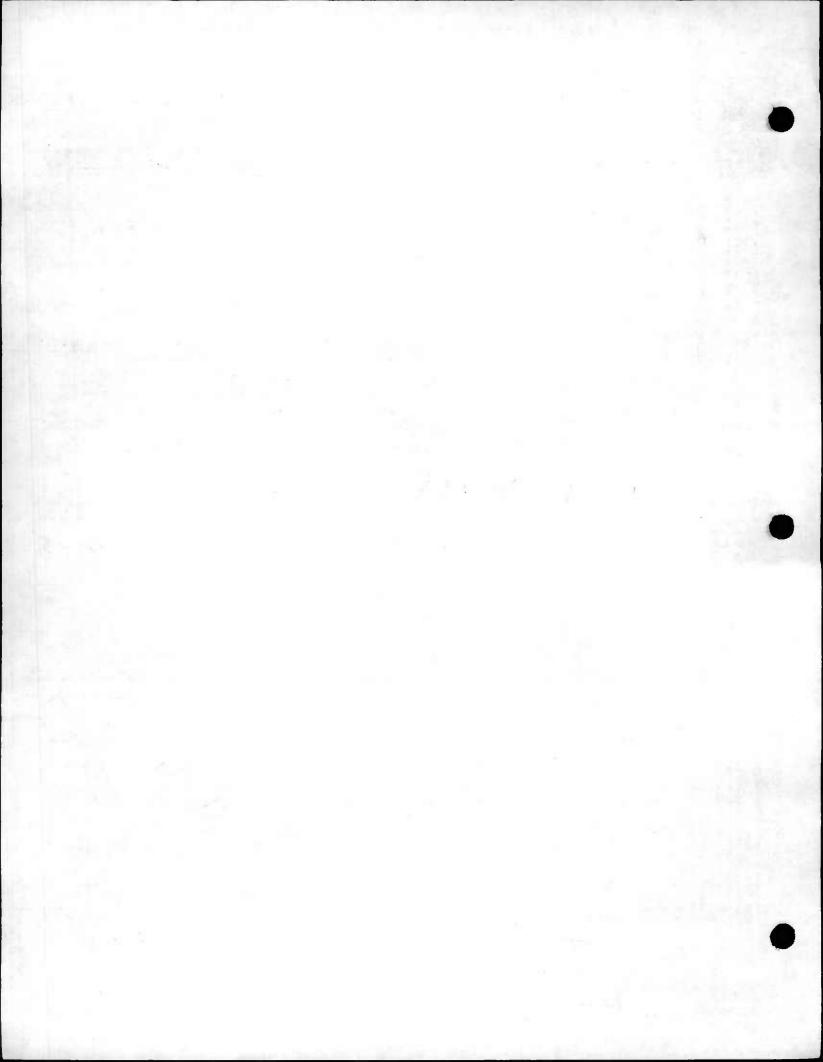
JUN 2 8 2000

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

Louis V. Kaufman, MD 9131 Piscataway Road Clinton, MD

B. Sparks



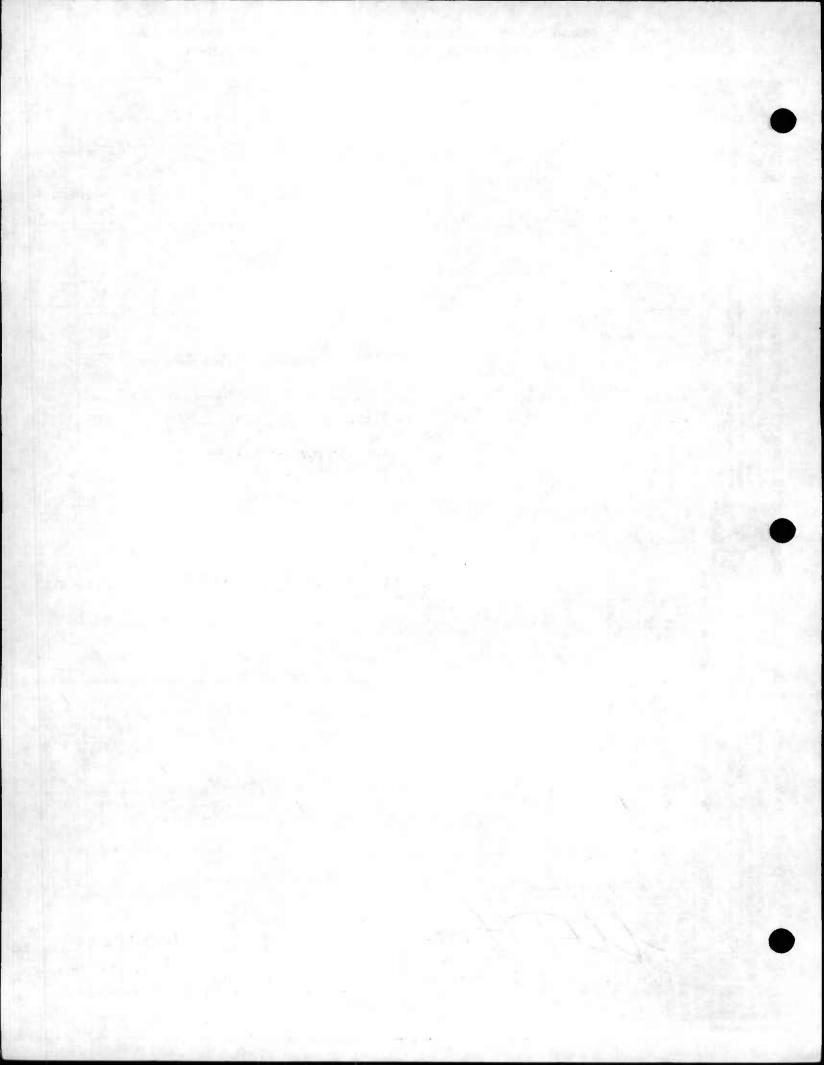
State of Maryland / Department of Health and Mental Hygiene 00 22030

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James Robert Willson Wife 9907 Capital View Avenue, Silver Spring, MD 201 200 Method of papeation 190 Method of	ted other than it event, the it event, the ite				retired)		т 1	ъ.	. 1			
James Robert Willson Wife 9907 Capital View Avenue, Silver Spring, MD 201				Goldsmith	10 Motho	re Name /First Middle			ail			
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JOHN WALLHALK, PH. 7/U/ MEGICAL PARK DRIVE, KOCKVILLE, MD /U850					D = =1 •	11. MD 20.	950					
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with the Mu e or 28e-f . De notifie				10f. Zip Code			10g. Citizen of W	hat Country?
020 ors after death v if, or flems 23s Examiner must		12. Was Decedent Armed Forces	?	13. Wes Decedent of If Yes, specify Cu		pecify Yes or No o Ricen, etc.)		a - American Indien, k, White, etc. White
21215-0020 innin 72 hours al jens. Then "natural, or the Medical Exam	15. Deceden (Specify only higher	's Education it grade completed)	16a	Decedent's Usual Occi (Give kind of work don life. DO NOT use retii	upation e during most of wor	king	16b. Kind of Bu	sinass/Industry
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Mary alth and Mary 27 is mary c traumets	19e. Informant's Neme/Reletions			. Mailing Address (Street				Stete, Zip Code)
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requires that the deben signed by the should be detached	Dames	tia				10	Yes 2 No	3 Probably 4 Unknown
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The law requires that the death cert are has been signed by the attending page 2 should be detached for use.			11.00	ART LEAST			ormed?	available prior to completion of cause of death?
Of Vital Rec Physician: The law this certificate has ral director, page 2						10	Yas 2 No	1 ☐ Yes 2 ☐ No
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Hospi 24 hou Funer italy fill	29a. Certifier (Check only one) Certifyin	g Phyelcian: To the best Examiner: On the basis of end menner st	of examinetion ar	e, deeth occurred at the ad/or investigation, in my	time, date end plece opinion, death occu	, end dua to the erred at the time	a causa(s) and ma , data and placa, e	nner es stated. and due to tha ceuse(s)
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W.	30. Nema and address of person	who completed ceuse of	death (Item 23a)	~ 1	1060-		ATO	. DO #421
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day June 27, 2000 Month Yaar Physician Marguerite Estelle Ward 3:01 am /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Holy Cross Hospital Silver Spring
| H Under 24 Hrs. | 8 Data Montgomery If Under 1 Year 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2□XE Yes 80 Director 214-14-5974 Mar 1, 1920 Maryland **Usual Residence of Decedent** 10a Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "naturel", or items 23s or 28s-f show traumatic event, the Medical Examinar must be notified at t ☐ Yes 2X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10g. Citizan of What Country? 321 University Blvd., West Apt 127 20901 USA deeth Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) t4. Race - American Indian. Black, White, atc. a filed within 72 hours efter of Hygiena. 1 ☐ Never Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White 3 D Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary Clerical permit. Pages 1 and 2 should be flia
Department of Health and Mentel Hy
Important: If Item 27 is marked othe
eny Injury or other traumatic event 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be William C. Folsom Bessie Marguerite Schultze 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Coda) Loretta M. Sutton / Daughter 20808 Brooke Knolls Road, Laytonsville, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 6/30/00 Rockville, MD Parklawn Memorial Park 22 Name and Address of Facility
Francis J. Collins Funeral Home, Inc. 21. Signature of Funeral Service License 500 University Blvd., W, Silver Spring, MD 20901 23a Part Enter the disease or primplications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death Physician CONGESTIVE HEAVE FAILURE

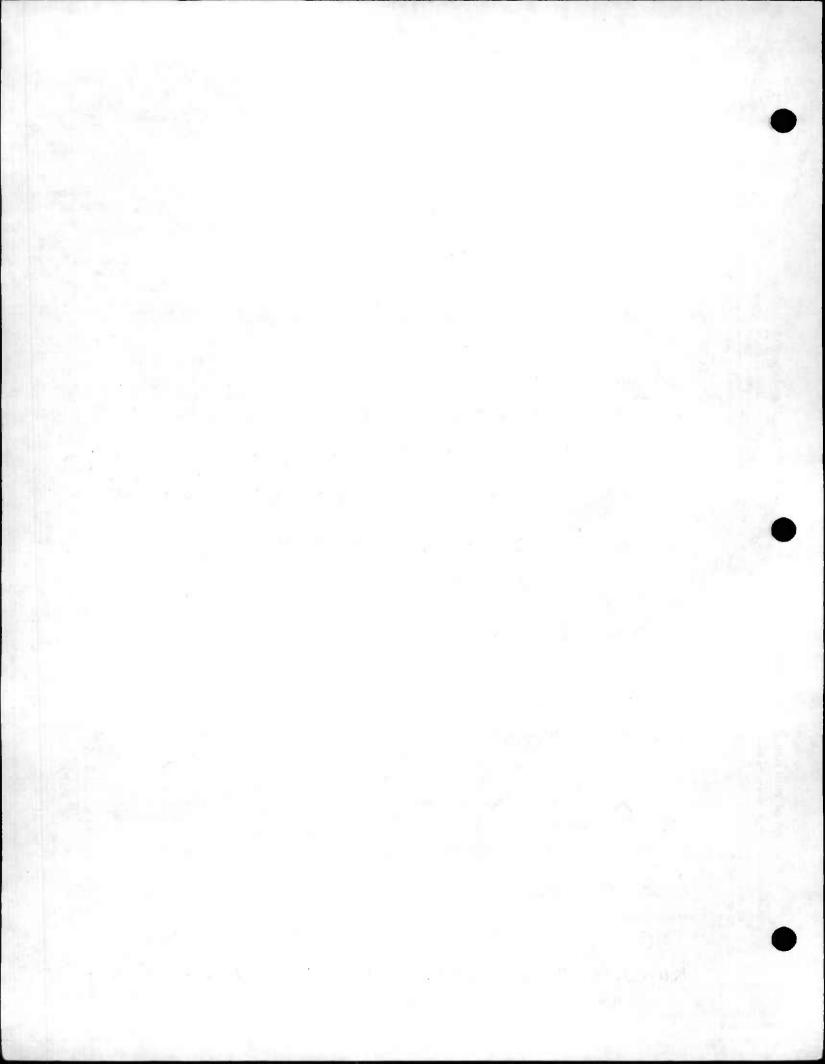
Due to (or as a consequence of):

MITRAL REGURGITATION fmmediate Cause (Final disease or condition resulting in death) /Medical MONTH S Examiner Physiclan/Medical Examiner ~24EARS attanding physician and for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) - ZYEMS P.O. Box 68760. KADIATION THERAS Due to (or as a consequence of) TUMOR OF THE LUNG-= 2 YEARS ARCINOID Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 2 No 1 Yee 3 Probably 4 Unknown PLEURAC EFFUSION þ Records. 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy VENTRICULAR TACHY CARDIA 1 Yas 2 No 1 Yas certificate of Vitai To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartification of the funeral director; the function of the function 25. Was case referred to medical examiner? 26. Placa of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nopatient 2 ER/Outpatient 3 DOA Certification: To 27. Manner of De 18 Natural 2 Accident 28c. Injury at Work? 28a. Data of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide edical 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and titla of questing 29c. License number 29d. Data signad (Month, Day, Year) ouser 3 e and address of ed cause of death (Item 23a) (Type, Print) 245 MUSGROVE 10 #209 SILVER SPRING, MD 20904 GINSBERG MO \mathcal{I}_{i} 31. Data filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First Middle Last) 2. Dete of Death 3. Time of Death Month **Physician** 26, Robert Ingersol1 June 2000 8:02 pm /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not Institution, give street and number) 4c. County of Deeth Examiner 11704 Lytle Street Wheaton Montgomery If Under 1 Year Birthplece (State or Foreign Country) 5. Sociel Security Number If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 1(X)M 2□ F 7. Age (In yrs. lest birthdey) **Funeral** Months Days Hours 86 Yrs. Director Nov 28, 079-16-8613 1913 New York Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show be notified at 1 Yes 2 No Director Maryland | Montgomery Wheaton 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? with ò than "natural", or hams 23a the Medical Examiner must (Funeral 11704 Lytle Street 20902 death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Bace - American Indian 11. Merital Stetus Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental thysiena. Important: if item 27 is marked other than "natural", or item any Injury or other traumatic avent, the Medical Exercises ance. 1 TYes 2 No If Yes, Give Year or Detes: WWII 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: White Completed by 3 ☐ Widowed 4 Ø Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Defence Mapping Elementary/Secondery (0-12) College (1-4or 5+) Information Officer 12 Agency 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Benjamin Franklin Waite Katherine Eloise Snell 19a. tntorment's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 13710 Highland Road, Clarksville, MD Lovena A. Smith / Daughter 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burlel 2 ☐ Cremation 3 ☐ Removel from Stete 6/30/00 Alexandria , VA 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 21. Signeture of Funerel Service Licensee 22. Name end Address of Fecility Kei Stile Francis J. Collins Funeral Home, Inc. 500 University Blvd., W, Silver Spring, MD 20901 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical . Coronary Heart Disease years Examiner Due to (or as e consequence of): Physician/Medical Examiner Atherosclerotic Cardiovascular Disease years The law requires that the death certificate be axecuted use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury that initieted events resulting in deeth) Last Due to (or es a consequence ot): pue Box 68760. Due to (or as a consequence of): signed by the ar P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco uas contributa to the causs of death? 1 Yes 2 No 3 Probably 4 Unknown Records. P 24b. Were eutopsy findings availeble prior to completion of cause of deeth? page 2 should Completed 24a. Wes en eutopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☒ No certificate Division of Vital or Attanding Physician: director. 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Na Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To this funeral 27. Manner of Death 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Affer 1 Naturel 5 Pending s after death. 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) illed in by 4 Homicide 24 hours a Hospital 10 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end plece, and due to the cause(s) and manner stated. 29a, Certifier within 24 hor To the Fune completely fi edicai \$ 29d. Dete signed (Month, Day, Year) 29b. Signatire end title of certifier 29c. License number 2 D 52 808 27/00 *1 MS 50

State Registrar

DHMH 16 Rev 6/95

Docks

#307, Silver Spring, MD

30. Neme and address of parson who completed ceuse of death (Item 23a) (Type, Print)

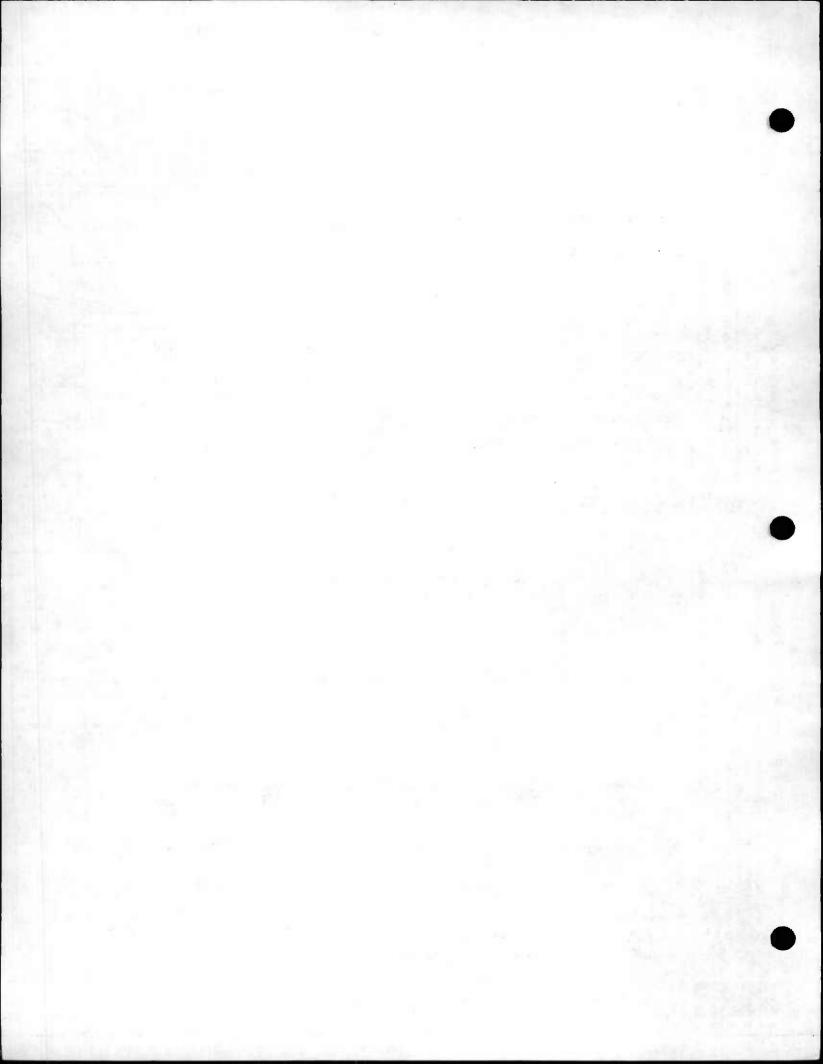
Herman Segal, MD

JUN 2 8 2000

31. Dete filed (Month, Day, Year)

10313 Georgia Ave.,

32. Registrer's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dela of Daath 3. Tima of Death June Yaar 6:40 Am Annie J. Whiteman 28 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Goodwill Mennonite Home Grantsville Garrett If Under 24 Hrs. B. Date of Birth (Month, Day, Year) 12/11/05 If Under 1 Yaar Birthplace (State or Foraign Country) MD 7. Age (In yrs. last birthday) 5. Social Security Number Days Months 1□M 2日F 94 215-05-2939 Vre Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Garrett Grantsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21536 TISA P. O. Box 310 12. Wes Decedent Ever in U,S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Pace - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: White Specify: 3 ₩ Widowed 4 Divorced 16a. Dacedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 8 Housewife Own Home 17. Father's Nama (First, Middla, Last) 18. Molher's Name (First, Middle, Maidan Surnama) Fannie Burkholder Nelson Wilt 19b. Malling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) 19a. Informanl's Name/Relationship (Type, Print) Charles Lancaster 187 Montague Road, Addison, PA 15411 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removel from State 06/30/00 Baptist Cemetery Confluence, PA 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility Humbert Funeral Home las P. O. Box 37, Confluence, PA 23a. Pert1. Enter the disease, of complications that ceusad the death. Do not enter tha moda of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Daeth Immediate Cause (Final disaase or condition resulting in death) PATIVE car to (or as a consequence of): (aus Sequentially list conditions, if any, leading to immadiate cause. Enler Underlying Cause (Disease or Injury that initiated evants resulting in death) Last Due to (or as Due to (or as a consequence of): Part IJ-Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ATROKE revious 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Plece of Death (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

Director

Funerai

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Completed

Be

0

MD

Funeral

Director

New 27 is marked other than "naturel", or Nems 28s or 28s-f show other traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: If Item 27 Ia marked other than "naturel", or her any Injury or other traumatic event, the Medical Exerci-

Baltimore, Maryland 21215-0020

the Menylend

death

Examiner physician end s the burial-tran the 10 Certification:

Physician/Medical þ Completed Be

The law requiras that the death certificate be executed Division of Vital Records, P.O. Box 68760, usa as attending Po eta has been signed by the apage 2 should be datached certificeta Hospital or Attending Physician:
 24 hours efter death.
 Funeral Director: After this certifice funeral

State Registrar

Medical

30. Name and address of person who completed cause of death (item 23a) (Type, Print) E 15c. alphos 31. Date filed (Month, Day, Year) 2000

1 Yes 2 No

27. Manner of Deeth

1 Neturel

2 Accident 3 Sulcide

4 Homicide

(Check only

29b. Signature and title of certifier

29a. Certifier

1 Inpatient

28e. Dete of Injury (Month, Day Year)

2 ER/Outpatient 3 DOA

28b. Time of

28a. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify)

Injury

28c. Injury al Work?

1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to the cause(s) and menner as stated.

1 Yes

irantsville mo

2 No

2 Medical Examiner: On the besis of examinetion end/or investigetion, in my opinion, death occurred at tha tima, data and place, and due to the ceuse(s) end manner stated. 29d. Date signed (Month, Day, Year) 29c. License number

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how Injury occurred

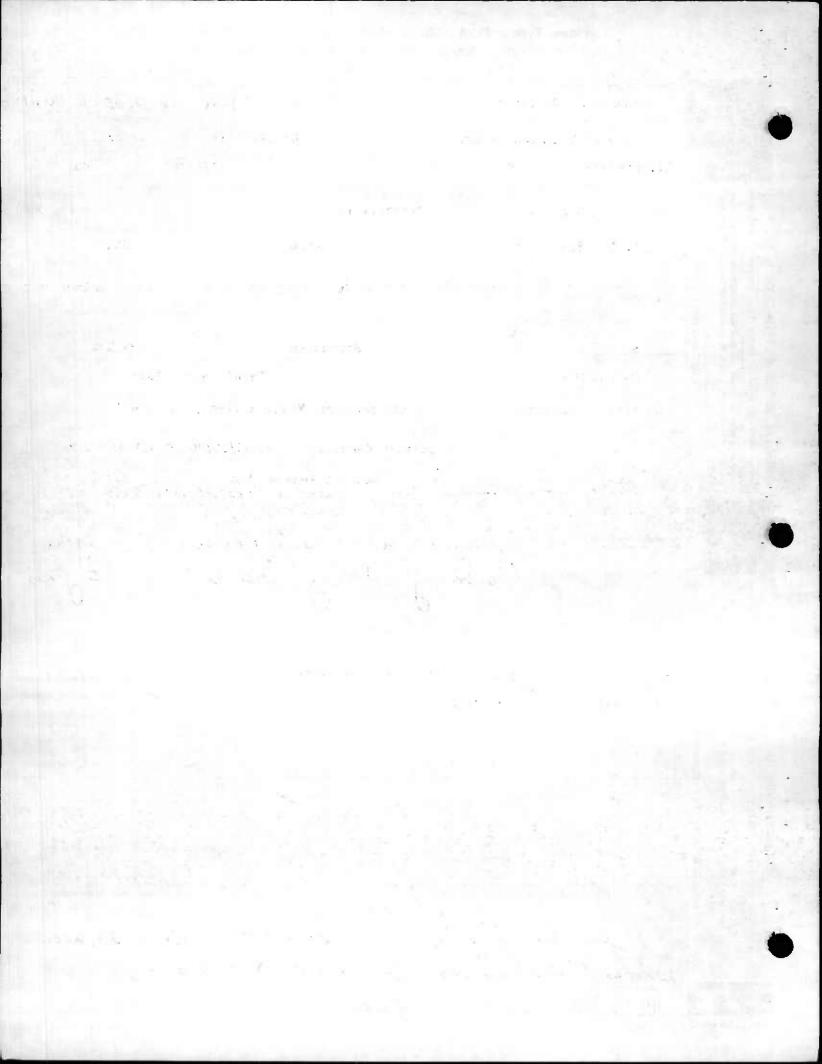
28f. Location (Street and Number or Rural Route Number, City or Town, State)

mo 32. Registrar's Signature

5 Pending investigation

6 Could not be daterminad

To the Within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month WASHINGTON **Physician** MARVA 21 11:50 AM 2000 UME /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Hospital The Johns HOPKINS Balt: more If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Social Security Number Age (In vrs. last birthday) **Funeral** Months 1 M 2 DF Director Usual Residence of Decedent tha Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show other traumatic event, the Medical Examiner must be notified at 1 TYes 2 No **Funeral Director** more 10g. Citizen of What Country? 10e. Street end Number permit. Pagas i and 2 should be filed within 72 hours after death with a Department of Haaith and Mental Hygiene. Important: If Item 27 is merked other than "nature." any injury or other traumatic average. Ver Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 10 No If Yes, Give 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Merried 2 Married 1□ Yes 2□ No Specify Be Completed by 1ac 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 1/14 NIA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Unknown 2 19b. Melling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) md. 2/2 Mother 20b. Placa of Disposition (Name of 20c. Location - City or Town, State Date 20a. Method of Disposition crematory or other 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Wol 600 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec of espiratory arrest shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Ceuse (Finel disease or condition resulting In deeth) /Medical PREMATURIT EXTREME HOUR Examiner Physician/Medical Examiner attending physician and for usa as the bunal-transit The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or es e consequence of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown CHORIOAMNIONITIS þ of Vital Records, 8 24b. Were autopsy findings evailable prior to completion of cause of death? Completed 24a. Was en autopsy performed? After this cartificate has 1□Yes No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica complately filled in by the funeral director, i 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Medical Certification: To Be Hospital: 1 Inpetient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Division 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 JUNE TWENTY FIRST, 2000

State Registrar 31. Dete filed (Month, Day, Year)

RUCHIRA GARG

1 1 2000 32. Registra

and address of person who conscieted cause of death (Item 23a) (Type, Print)

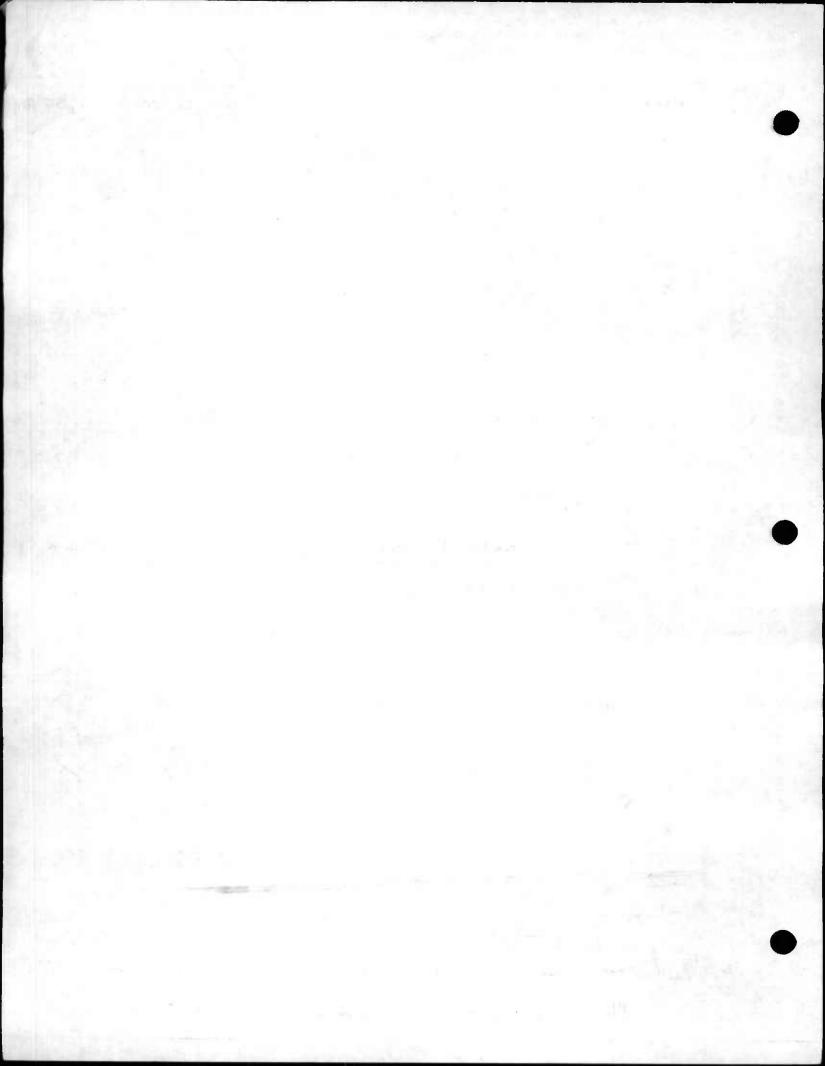
JOHNS HOPKINS HOSPITAL

32. Registrar's Signature

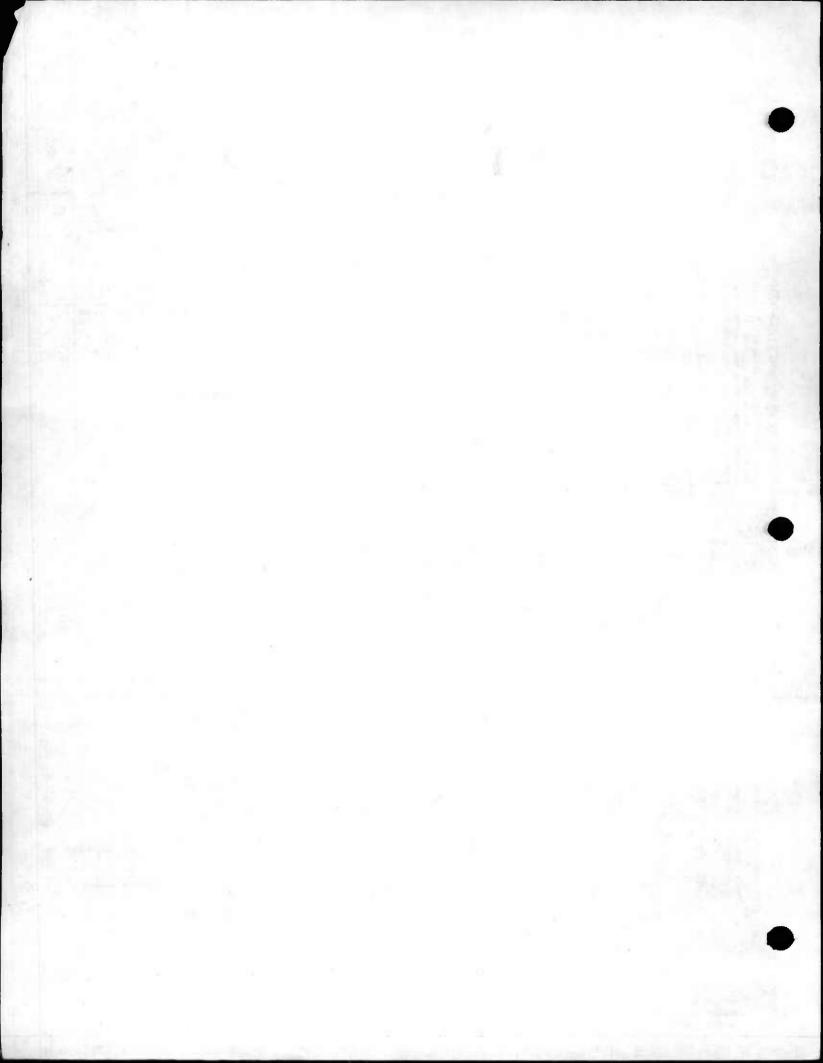
& Sports

600 NORTH WOLFE STREET

BALTIMORE, MARYLAND



	Certificate of Death		g. No.								
Physician	1. Decedent's Name (First, Middle, Last) Libbie Zucker	2. Date of Death Month June 24	Day Year	3. Time of Death 7:45 PM							
/Medical Examiner	4e Facility Name (If not institution, give street end number) 4b. City, Town, or Lo	1	4c. County of Death	7.45 []							
	5901 Montrose Road Apt. 1608 N Rockville		Montgomer	3							
Funeral Director	5. Social Security Number 045-14-8474 6. Sex 1 Months 1 M	8. Date of Birth (Month, Dev.) June 29,	Year) 9. Births Cour 1911 Bal	place (State or Foreigntry) timore, M							
D 8 m	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		1	Od. Inside City Limits							
ar death with the Maryland thems 23a or 28a-f show ner must be notified at uneral Director	MD Montgomery Rockville			1 ☐ Yes 2 ☐ N							
with the Ma to or 28s-f a be notified Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cour	ntry?							
e 23e nuet 2	5901 Montrose Road Apt. 1608 N 20852		USA								
72 hours after death vinatural; or itsms 234 fical Examiner must sted by Funeral	11. Marital Status 12. Wes Decedent Ever in U,S. Armed Forcas? 1 □ Never Married 2 □ Married 1 □ Yes 2 □ No H Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecity Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:								
re hou	15. Decedent's Education 16a Decedent's Usual Occupation	10	6b. Kind of Business/Inc								
ed within 72 ho yglene. wr than "natur it, the Medical. Completed	Elementary/Secondary (U-12) College (1-4or 5+)	kind of work done during most of working O NOT use retired)									
	5+ Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name		Guidance								
Mental F inked of rice ever To Be		Kallinsk									
SPEE	19e. Informant's Name/Relationship (Type, Print) (Daughter) 19b. Mailing Address (Street and Number or Rura		-	Code)							
and 2 pailth a n 27 is ser tra	Dr. Rebecca Z. Hertzman 12103 Devilwood Driv	e Potoma	c, MD 208	54							
Pages 1	20a. Method of Disposition 1 \overline{\Omega Burial 2 \subseteq Cremation 3 \subseteq Removal from State} 4 \subseteq Donation 5 \subseteq Other (Specify) 20b. Place of Disposition (Neme of camelery, cremetory or other place) Beth Alom 6	Date 20 /26/00	Oc. Location - City or To New Brita:								
Departi Departi Importu any inj ans inj	21. Signeture of Funeral Service Licenses 22. Name and Address of Facility. Metropolitan Fune 5517 Vine Street	ral Serv	ice, Inc.	2310							
	23a. Part. Einer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or hook, or heart failure. List only one cause on each line.			Approximate Intervel Between							
ifficate be axecuted gphysician and as the burial-transit tedical Examiner	disease or condition resulting in death) Due to (or as a consequenca of): Cause (Disease or injury that initiated events resulting in death) (Last Due to (or as a consequence of):			1							
5 0 6	d.	1 = 1	1								
the death cert d by the attendin etached for use Physician/N	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23b. Did tobacco use contribute to the cause of d									
es that the death cer igned by the attendir be detached for use by Physician/A		1 🗆 Yes	2 2 No 3 Pro	bebly 4 ☐ Unkno							
aw requir		24a. Was an performe	ed? av	ere autopsy findings allable prior to mpletion of cause death?							
The late he page		1 ☐ Yes	2 DUNG 1	Yes 2□ No							
ysician: The secrificate director, pag	25. Was case referred to medical examiner? 26. Place of Death	h (Check only one)	,								
0 0	Netural 5 Pending (Month, Day Year) Injury Work?	me 5 Residen 28d. Describe how	ca 6 Other (Specify Injury occurred	(y)							
tal or Attending P rs after death. al Director: After t led in by the funers Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	City or Town,	eet and Number or Rure Stete)	Al Route Number,							
To the Hospital or Attending Phy within 24 hours after death. To the Funeral Director. After thi completely filled in by the funeral Medical Certification: T											
	29b. Signature and title of certifier 29c. License number 700 0 (6 115	290	d. Date signed (Month,	Dey, Year)							
40	30. Name and address of person wito completed cause of death (Item 23a) (Type, Print) MacC 12/12/14/14 01/46/01/46/01/47/40/4	a Rd &	Inctville	MO 218							
State Registrar	31. Dete filed (Month, Day, Year) 11 IN 2 6 2000 32. Registrar's Signature 4. Sports	10	VI - 1.14								



	Sandaria Nama (First Middle I		nd / Department of Health an Certificate of Death	Reg. No.	22037					
ysician	Decedent's Name (First, Middle, La	(1)	Doubt	2. Date of Death Month Day	ar 3. Time of Deeth					
Medical	Sose ph	tterry	Brech	July 6 Luci) de Am					
kaminer	4a Facility Name (If not institution, giv	e street and number)	1646 01	n, or Location of Death 4c. County of	Death					
	University of	MARY JANG NIN	edient Dystems Bloder 24	more n/a						
neral		100 M 2015		Min. (Month, Dey, Year)	Birtholeca (State or Foreig Country)					
ector	215-42-9574 Usual Residence of Decedent	5.	5 113.	Sept. 16, 1944 1	Maryland					
**	10a. State 10b. County	10c. C	City, Town or Location		10d. Inside City Limits					
to to	Maryland n/a	Ra	ltimore		1 ☐ Yes 2 □ No					
be notifie Directo	10e. Street and Number	Du	10f. Zip Code	10g. Citizen of Wha	at Country?					
	State of the state	4.	21229							
iner must Funeral	3205 Strickland S			United (Specify Yes or No- 14. Rece -	States American Indian,					
Pur Per	1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 XYes 2 No		Puerto Rican, etc.) Bleck,	White, etc.					
by F	3 Widowed 4 Divorced	If Yes, Give Year or Detes: 1968	3-71 1□ Yes 20\(\text{No}\) Specify:	Specify:	White					
	15. Decedent's Ed	ducation	16a Decedent's Usual Occupation	16b. Kind of Busin	nece/industry					
t, the Medical Completed	(Specify only highest gre	rede completed)	(Give kind of work done during most of life. DO NOT use retired)	f working	less industry					
E MO	Elementery/Secondary (0-12)	College (1-4or 5+)	lathe operator	rubber						
	17. Father's Name (First, Middle, Last)			Name (First, Middle, Maiden Surneme)						
o Be										
The P	Louis Henry Brech 19a. Informant's Name/Reletionship (Alice 19b. Mailing Address (Street end Number of	America Dixon	Tie Code)					
traumetic eve To Be										
2	Marlene E. Brecht - wife 3205 Strickland Street, Baltimore, Maryla 200. Method of Disposition 200. Place of Disposition (Neme of Dete 200. Location - City or 7									
ò	1 XBurial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cremetory or other place)							
Š.	4 Donation 5 Other (Specific	(y) Bal	ltimore National Cemet							
4 6	21. Signature of Funeral Service Licer	1500		Hubbard Funeral Hom 4107 Wilkens Avenue						
2 0	1 unny	Link		410/ Wilkens Avenue Baltimore, Maryland						
	23a. Pert1. Enter the disease, or com	plications that caused the dea	ath. Do not enter the mode of dying, such as call		Approximate Interval Between					
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ansit		Man 15	BRAIN Insury		1					
S. 15	Sequentially list conditions.	b. Anor 10	for an a consequence of	,	1					
5 5	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying	11.11:1	Oncion System Fai	7 /						
Exarr	Cause (Diseese or Injury that initiated events	c. / lurriple	(or as a consequence of):	fune						
e bunal-transit icai Examin		/ Duo 10	or as a consequence on.							
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is the buriel-tr	resulting in death) Last	0.								
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director, page 2 should be detached for use as the burial-th To Be Completed by Physician/Medical Exi	25. Was case referred to medical examiner? 1 Yes 22. No 27. Manner of Death	Hospital: 12 Inpatient 2 2 28a. Date of Injury	26. Place of □ ER/Outpatient 3 □ DOA Other: 4 □ Nursi	1 Yes 2 No 3 24e. Was an eutopsy performed? 1 Yes 2 No	Probably 4 Onkno 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No					
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sctor, page 2 should be detached for use as the burial-to	25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 12 Inpatient 2	26. Place of ER/Outpatient 3 DOA Other: 4 Nursin 28b. Time of lnjury M Work? M 1 Yes 2 No	1 Yes 2 No 3 24e. Was an eutopsy performed? 1 Yes 2 No 3 24e. Was an eutopsy 2 1 Yes 2 No 9 1 Death (Check only one) 2 ing Home 5 Residence 6 Other 2 28d. Describe how Injury occurred	Probably 4 Inkno 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No (Specify)					

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0020

Registrar

State

29b. Signature end title of

Jon Janague
31. Date filed Month, Dey, Year)

Jon

DHMH 16 Rev 6/95

Month, Dey, Year)

JUL 1 2 2000 Server A

A grand of person who completed cause of deeth (Item 23a) (Type, Print)

22 South Brokene

32. Registrar's, Signature

4

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Date of Death Month **Physician** 2000 July 2250 Adeline Elizabeth Batzer 6 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Atlantic General Hospital Berlin Worcester If Under 1 Year If Undar 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stata or Foraign Country) **Funeral** Days Months Hours 1□M 20 F Yrs 93 217-26-0084 Director Jul 29, 1906 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limita 1 ☐ Yas 2 K No Director Delaware Sussex Frankford 10g. Citizen of What Country? 10a. Street and Number 10f. Zin Code 19945 Rt 2 Box 133-H Funeral U.S.A. 14. Raca - Amarican Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11 Marital Status Was Decedent Ever In U.S. Armed Forcas? 1 Never Married 2 Married 1 ☐ Yas 2 ☐ No If Yes, Give Maryland 21215-0020 1 Yes 2 No Specify. White þ Specify: 3 ☐Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 6 0 18. Mother's Name (First, Middla, Maidan Surnama) 17. Fathar's Name (First, Middla, Last) Be Mental Pages 1 and 2 should be George Clements Justine Krause 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) partment of Health portant: if Item 27 i Rt 2, Box 133H, Frankford, Delaware 19945 Mildred M. Elderkin / daughter Saltimore, 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20c. Location - City or Town, Stata 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 7/11/2000 Baltimore, Maryland Loudon Park Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licansee 22. Nama and Address of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 cations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, in cause on each line. 23a. Part1. Enter the disease, or companies shock, or heart failure. List only Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical KENAL FAILURE Examiner Examiner TOXICITO The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequenca of) Box 68760, on62577VE Physician/Medicai the Due to (or as a consequence of) **USB 88** 23b. Did tobacco use contribute to the cause of deeth? P.0. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page 2 should Completed this certificate hes 20 No 2 No 1 Yas 1 Yes after deeth. Director: After this certifics d in by the funeral director, 25. Was casa refarred to medical examinar? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1☐ Yes 2☑ No 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred or Attending Division 5 Pending Invastigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be detarmined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 26b. Signature and title of certifier 29c. Licensa number 29d. Date signed (Month, Day, Year) 2000 30. Name and address of person who completed cause of death (Itam 23a) Type, Print)

Registrar

State

714 Healthway

2000

31. Data filed (Month, Day, Year)

-26

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ORIGINAL

Drove

32. Registrar's Signatura

00-3776-041 Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. jhm State of Maryland / Department of Health and Mental Hygiene ELAINE KAY Certificate of Death BRIGHTBILL 1. Decedent's Name (First, Middle, Last) 2. Dete of Death Dev Month **Physician** Elaine K. Brightbill JULY 09,2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROUTE 50 AT BUCK BRYAN ROAD TALBOT 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplaca (State or Foreign Country) **Funeral** Deys Months 1□M 217F 50 Yrs Aug. 31, 1949 Director 210-40-1499 Pennsylvania Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County rms 23a or 28a-f show Director Perry Co. 660 Mountain Road 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with till Department of Health and Mental Hyglane. Important: If item 27 is marked other than "natural", or herns 23a or 2 any Injury or other traumatic event, tra Medical Examination must be as the state of the contract of the medical Examination of the contract of the medical Examination of the contract of the co 660 Mountain Road 17062 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 Ø No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - Amarican Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Merried Baitimore, Maryland 21215-0020 1 Yes 2 No Specify: specity: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Hairdresser Beauty 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surname) Chester Killheffer Jean Ricker 19a. Informant's Name/Ratationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) M. Donald Brightbill 660 Mountain Road, Millerstown, PA 17062 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) Phoutz Valley U.M. Cem. 7/15/00 Millerstown, PA 22. Nama and Address of Fecility 21. Signature of Funeral Servide Lice Witzke Funeral Homes, Inc. M/OBEV/1630 Edmondson Avenue, Catonsville, MD 21228 23a. Part/. Enter the disease, or complications the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MULTIPLE INJURIES Examiner Examine physician and the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of) P.O. Box 68760, Physician/Medical Due to (or es a consequence of): Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by ti should be detach 1 Yes 2 No 3 Probably 4 Unknown Records, à 24b. Wara autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 Yes 2 No

13:50 PM

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 Pres 2 No

1 Yas 2 No

The law requires that the death certificate be assocuted

Division of VItal Attanding Physician: death. Director 6 24 hours To the Hosp within 24 hor To the Fune completely fi

8 this After thi

Certification: To

U

ri pelli

State Registrar

DHMH 16 Rev 6/95

5 Pending

investigation

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

6 Could not be

25. Was case referred to medicat examiner?

1⊠ Yas 2□ No

27. Manner of Death

1 Natural

2 Accident

3 ☐ Suicide

29a. Certifier

4 ☐ Homicide

(Check only one)

29b. Signature and titig of certifig

31. Date filed (Month, Day, Year)

RIPPUL, M.D. 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signeture

MIN

28a. Deta of Injury (Month, Day Year)

9/00 FOUND

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of OVND

1344

M

ROADWAY

28c. Injury at Work?

1 Certifying Physician: To the best of my knowledga, deeth occurred at tha tima, data and place, and dua to the cause(s) and mannar as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, daeth occurred at the time, data and place, and dua to the cause(s) and mannar stated.

OCME

29c. License number

26. Placa of Death (Check only one)

Other: 4 Nursing Home 5 Residence & Other (Specify) SCENE
Injury at Work?

DRIVEN OF CAR WHICH STRUCK

BRYAN

FIXED OBJECT

ROMO

28f. Location (Street and Nymber or Bural Route Nymber, City or Town, State) LT, 50 AT BUCK

29d. Date signed (Month, Day, Year)

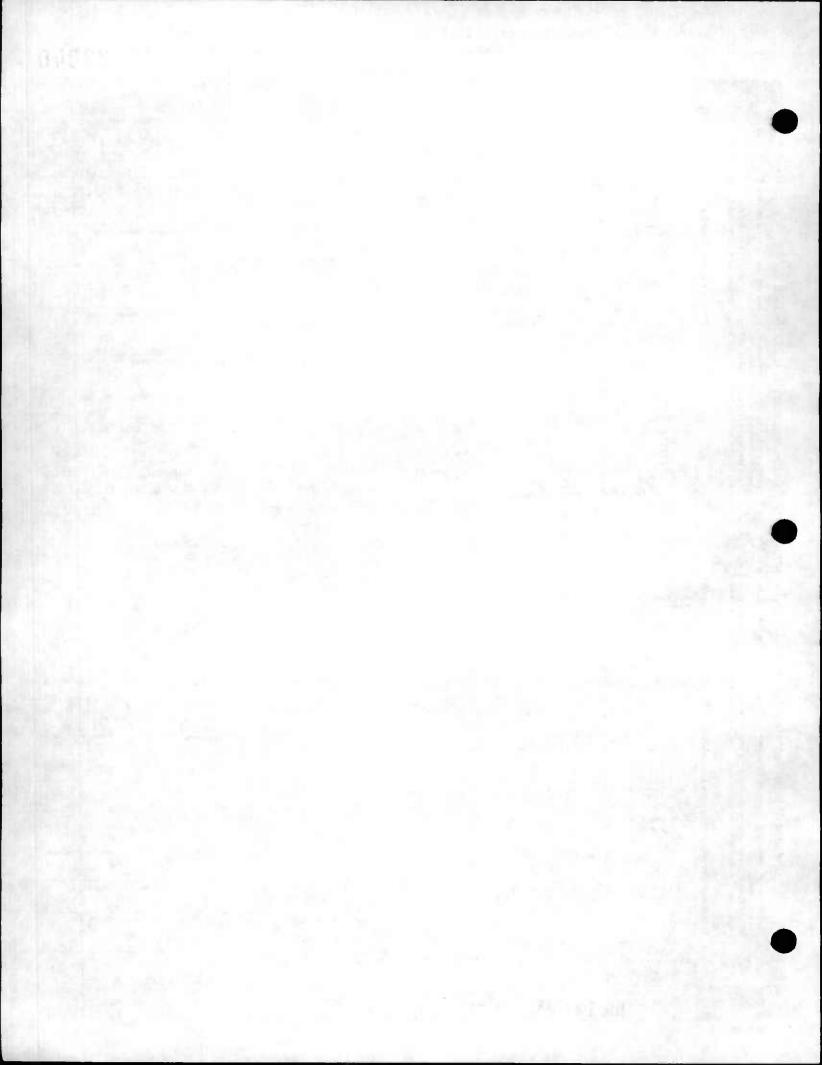
JULY 10, 2000

ORIGINAL

Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

Physician	Decedent's Name (First, Middle, Las	Sr)		2. Date of Death Month Day			Yeer	3. Time of Death		
/Medical	Albert William	9		0, 2000	0	6:05 am				
Examiner	4a Facility Name (If not institution, give		1	4b. City, Town, or L	ocation of Deeth	4c. County	of Deeth			
الإسب	9 North Prospect					Catonsvi.		Balt:		
Funeral Director	5. Social Security Number 6. Security Number 216-07-0416	ex 7. Age	84	Yrs. If Under Months		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey Feb. 7, 1		9. Birthple Countr Mary	ce (Stete or For y) land
B 10	10a. State 10b. County		10c. City, Tow	n or Location					10	d. Inside City Lin
23a or 28a-f ahow List be notified at ral Director	MD Baltimo	200	Cata	nsville						1 ☐ Yes 2 📆
be nothers Director	10e. Street and Number)IE	Cato	10f. Zip	Code	V	1	0g. Citizen of	Whet Countr	y?
300	9 North Prospect	Avenue		212	28			USA		
r ttems 234 free must Funeral	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U,S.			dispanic Origin? (Sp en, Mexican, Puerto	ecify Yes or No-	14. Rad	ca - America	
, o	1 Never Married 2 Married 3 Widowed 4 MDivorced	1 Yes 2 N If Yes, Give Year or Dates:		1 Yes			Hican, etc.)		ck, White, et y: Whit	
"natural". edical Em	15. Decedent's Ed	ucation	16a.	Decedent's Usua	ol Occup	pation	ina	16b. Kind of B	usiness/indu	stry
	(Specify only highest grad	de completed) College (1-4or 5-	+)	life. DO NOT us	se retired	during most of work d)	any .			
Hyglene. ther than mt, me	10	Ø		Manager				Pharma		
155 -	17. Father's Neme (First, Middle, Last)					18. Mother's Nam	e (First, Middle, I	Maiden Sumer	ne)	
To Etc	Philip C. Buchwal					Louise	Wiessne	r		
E E E	19e. Informent's Name/Reletionship (T	****	19b	. Meiling Address	(Street	end Number or Rui	re/ Route Number	r, City or Town	Stete, Zip (Code)
Health em 27 I other tr	Louise Mathis/Dau	ghter	R	ural Rt	4, E	320-E	Sneedy	ille,	Cennes	see 378
22.	20e. Method of Disposition 1 2 Burial 2 Cremation 3 1	Removal from State	20b. Placa of cemete:	f Disposition (Ner ry, crematory or o	ne of ther plea	ce)	Date	20c. Location	- City or Tow	n, State
	4 Donation 5 Other (Specify			awn Ceme			/12/00	Woodlav	vn, Ma	ryland
Department Important: 8 any injury o	21. Signature of Funeral Service Licens	500	M0074			ss of Facility	Witzke nue. Cat			
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Medical aminer	Immediate Cause (Final disease or condition resulting in deeth)	a	uci s	consequence of:			le	,		nterval Between
physician and stress the buriel-transit edical Examiner	disease or condition	b. <i>E</i>	Oue to (or as a complete to or as a complete to core as a core as	www			- 1	,		nterval Between
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22041 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death 2000 JULY 08 **Physician** 12:25P ALLUSTUS D. BROWN /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE SINAI HOSPITAL ff Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday). 50 Yrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** Days Hours 1□ M 2XF Director 216-54-6118 12 - 31 - 49MD Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23a or 28a-f show idical Examiner must be notified at 1 X Yes 2 □ No Director MD BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? U.S.A. 21216 3307 SPRINGDALE AVE death Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, Whife, etc. 11. Meritel Stetus permit. Pages 1 and 2 should be filed within 72 hours after c Department of Heath and Mental Hygiene. Important: if item 27 is marked other than "natural", or then any Injury or other traumatic event, the Medical Examinat 1 □ Never Married 2 □ Married 21215-0020 1 ☐ Yes 2 No Specify: Specify: BLACK þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) DISABLED 1.0 DISABLED Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be FLOYD W. DUFFY ELMA BAKER 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3307 SPRINGDALE AVE, BALTO. MD 21216 TANYA QUEEN 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1X Buriel 2 Cremetion 3 Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7-13-00 LANSDOWNE, MD MOUNT ZION 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Howell Funeral Home 4600 LIBERTY HGHTS AVE, BALTO, MD 21207 Approximete Intervel Between Onset end Deeth 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Ceuse (Finel disease or condition resulting in deeth) /Medical VENTRICULAR FIBRILLATION 1 HOUR Examiner Due to (or as a consequence of): Physician/Medical Examiner HYPERKALEMIA siclan and bunal-transit 24 HOURS The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): physician is the bune END-STAGE RENAL FAILURE Box 68760. UNK Due to (or es a consequence of): DIABETES UNK P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 No 3 Probably 4 Unknown signed b Records. ò ate has been si page 2 should I Completed 24b. Were autopsy tindings evailable prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital or Attending Physician: after death. Director: After this certifica director, Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospifal: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menner of Death 28b. Time of 28d. Describe how injury occurred Division 5 Pending investigation 1 Naturel 1 Yes 2 No 2 Accident To the Hospital or Atterwithin 24 hours after del To the Funeral Directo completely filled in by the 6 Could not be determined 3 Suicide 28t. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide edical 1 X Cartifying Phyeiclan: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner es stated.
2 Mad cal Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end manner stated. 29e, Certifier 29b. Signature and title of certife 29c. License number 29d. Dete signed (Month, Day, Year) D25379 JULY 08, 2000 30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print) N

State Registrar

DHMH 16 Rev 6/95

JOFFE,

1 2 2000

STEVEN L.

31. Dete filed (Month, Day, Year)

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MD SINAI HOSPITAL

32. Registrer's Signeture

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2142 W. BELVEDERE AVE, BALTO. 21215

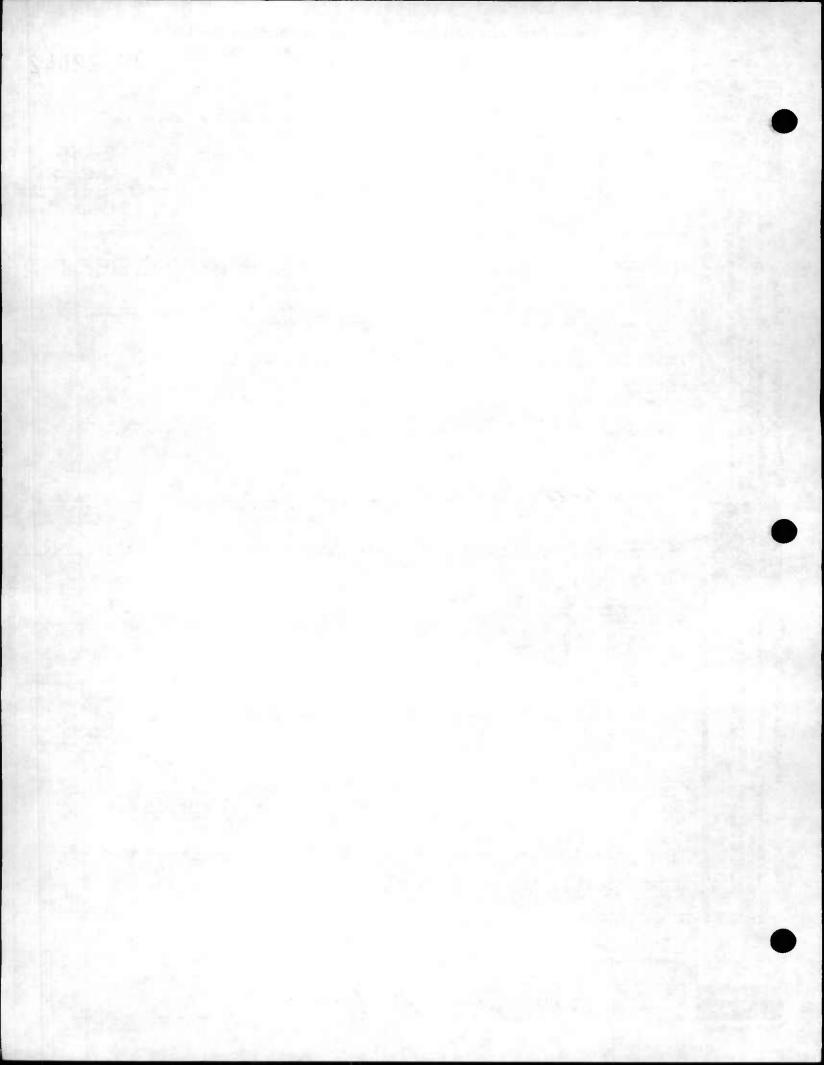
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State of Maryland / Department of Health and Mental Hygiene 22042 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2000 Month **Physician** July Bongiovano 10:40 pm Charles /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 974 PunJab Circle Essex Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** 1 € M 2 □ F 217-16-4802 76 Director 3,1923 MARYLAND Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Peges 1 and 2 should be filed within 72 hours after deeth with the Marylan nent of Health and Mentel Hygiene.

ant: If item 27 is marked other than "naturel", or items 23s or 28a-f ahow ury or other traumatic event, the Wederal Examinar must be nothered. 1 ☐ Yes & No Funeral Director BALTIMORE **ESSEX** 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 974 PunJab Circle 21221 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Raca - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married 1 √ Yas 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. þ Specify WHITE 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Transportation 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown Margaret DeLuca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health at Important: if item 27 is eny injury or other trait page. John Bongiovano - Son 974 PunJab Circle Baltimore, Maryland 21221 20b. Place of Disposition (Nama of cemetery, crematory or other place) 7/8/00 Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore-Washington Crematory Laurel, Maryland 21. Signature of Funaral Sarvice Licensee 22. Name and Address of Facility Charles S. Zeiler & Son, Inc. 6224 Eastern Avenue Baltimore, Maryland 21224 Approximata Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or read failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical OF UNKNOWN Examiner Due to (or as a consequenca of): Physician/Medical Examiner The law requires that the death certificate be executed as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. attanding physician Due to (or as a consequence of): Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 3 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? page 2 should been : certificate hes 1 Yes 2 No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatiant 1□ Yes 2 No Othar: 4 ☐ Nursing Home Residence 6 ☐ Other (Specify) Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manaar of Death 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending investigation ours after death. heral Director: Al 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcide within 24 hours a
To the Funeral C To the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29c. License number 29b. Signature and title of cartific 29d. Date signed (Month, Day, Year) ulu 6 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) hAR 31. Date filed (Month, Day, Year) 32. Registrar's Signatura State 2000 12 Registrar

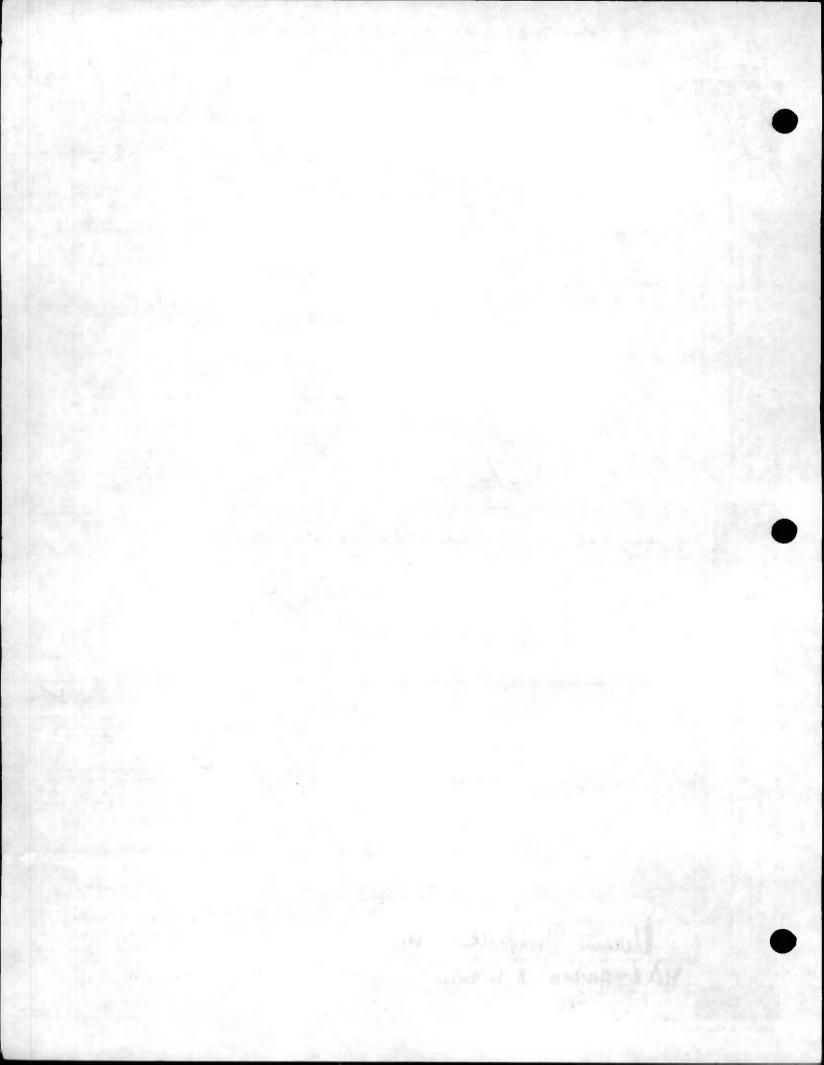
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle Last) 2 Date of Deeth Dey Year **Physician** Charles J. Constantino 11:18 Pm 2000 JULY /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner BALTIMORE ST. AGNES n/a HOSPITAL If Under 1 Yeer | If Under 24 Hrs. | 8. Dete of Birth Months | Deys | Hours | Min. | Min. | March 10, 1932 | Maryland 5. Sociel Security Number Birthplece (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 10 M 2□ F Yrs. Director 212-30-7938 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. inside City Limits 1X Yes 2 No Maryland Directo n/a Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whel Country? b a 23a 423 S. Bentalou Street 21223 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 11. Meritel Stetus filed within 72 hours after 1 Never Married 2 Merried 3altimore, Maryland 21215-0020 b 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementery/Secondery (0-12) Coltege (1-4or 5+) 12 cashier/stock clerk grocery store 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be permit. Pages 1 and 2 should be 1 Department of Health and Merrial important: If Item 27 is merked of any Injury or other traumatic ave Charles R. Constantino Harriet J. Amey 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurei Route Number, City or Town, Stete, Zip Code) Vivian A. England - sister 423 S. Bentalou Street, Baltimore, Maryland 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20e. Method of Disposition Dete 20c. Location - City or Town, Stele 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/10/00 Loudon Park Cemetery Baltimore, Maryland 21. Signeture of Funeral Service Licens 22. Name and Address of Fecility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue 21229 Baltimore, Maryland Approximete Intervat Between Onset end Death 23e. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause of each line. **Physician** SEPTIC SHOCK Immediate Cause (Finet disease or condition resulting In deeth) /Medical UNKNOWN Examiner Due to (or es a consequence of) Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in deeth) Lest Due to (or es a consequence of): CONSTANTINE Due to (or es a consequence of) Pert It. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? Be Completed 24e. Wes en autopsy performed? 20 No this certificate 1 Yes 25. Wes case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes > No Hospitel: 1 Nnpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To to 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how Injury occurred Atter Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pleca, end due to the ceuse(s) end menner as stated. 2 Medical Examiner: On the besis of exeminetion end/or investigetion, in my opinion, deeth occurred at the time, date end placa, and due to the cause(s) and menner steted. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) MI) P19600 JURY, 7, 2000 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) 900 CATON AVE BALTIMORE MD ST. AGNES HOSPITAL

Registrar DHMH 16 Rsv 6/95

State

NASSERI

31. Dete filed (Month, Day, Year)

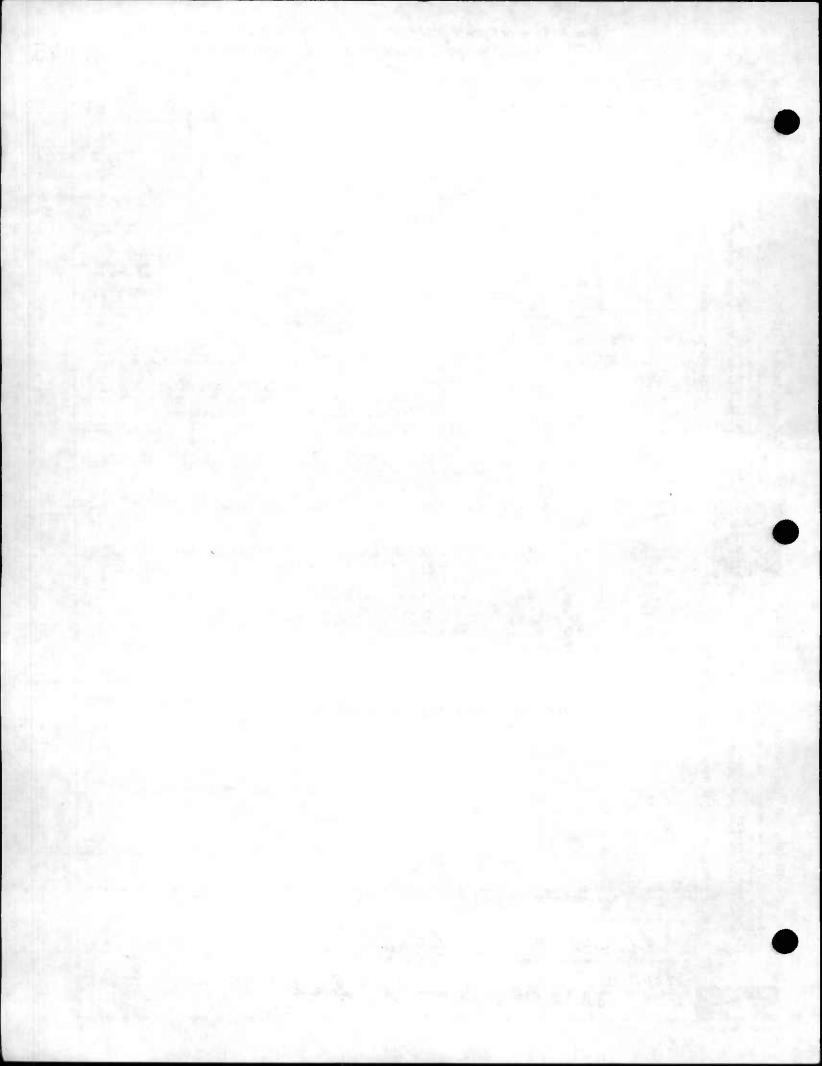
2000 32. Registrat's Signeture

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Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Frances Elizabeth Clements 2000 1:52 P.M. /Medical 4e Facility Name (If not institution, give streat end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4630 Rokeby Rd. **Baltimore** N/A If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) Date of Birth (Month, Dev. Year) 01 25-1926 5. Social Security Number 7. Age (In yrs. last birthdey) **Funeral** Deys Hours 1□M 2₩F Yrs 216-24-0382 74 Director North Carolina Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 23a or 28a-f ahow N/A M Baltimore 1X Yes 2 No must be notified Director 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 4630 Rokeby Rd. 21229 USA Funeral Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus ☐ Never Married 2☐ Married Specify: Black 21215-0020 6 1 Yes 2 No Specify à 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry I Hygiena. Elementary/Secondary (0-12) College (1-4or 5+) Housewife Domestic Department of Health end Mental Hygis Important: If Item 27 is marked other any Injury or other traumatic event, is Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 8 Joseph Ray Elnora Ray 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code) Joyce Handy 4630 Rokeby Rd. Balto., Md. 21229 (Daughter) Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 XBuriel 2 ☐ Cremation 3 ☐ Removal from State New Cathedral Cemetery 7-14-00 Balto., Md. 21229 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Caple Funeral Service 21. Signature of Funeral Service Licenses ennis 5502 Winner Ave. Balto., Md. 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or hear failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical immediate Cause (Final diseese or condition resulting in death) Examiner Examiner The law requires that the deeth cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. USB

Physician/Medical Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 1 Yes 2 No 2 100 25. Was case referred to medical Medical Certification: To Be 26. Plece of Death (Check only ope) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 1 Yes 2 No 3 Residence 6 □Other (Specify) 28a. Date of Injury (Month, Dey Year) 27. Menn of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

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29e. Certifier

29b. Signeture end title of certifier

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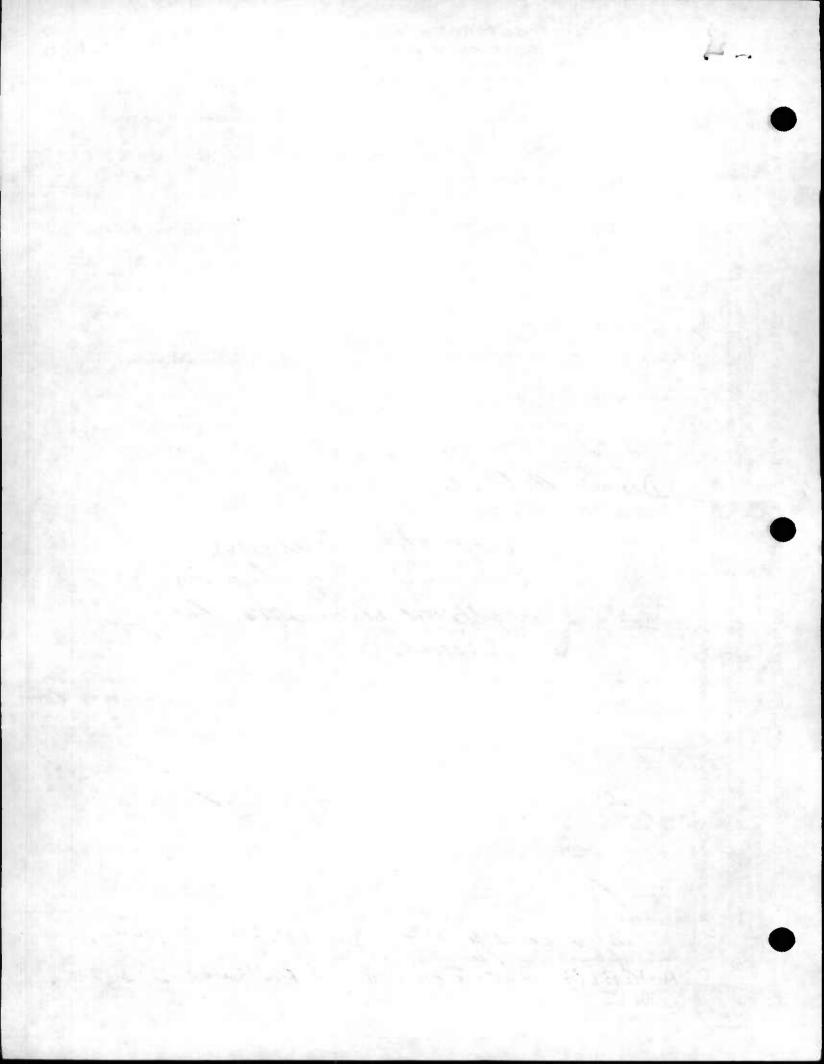
State Registrar D-0008780

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end plece, end due to the ceuse(s) and menner stated.

29d. Date signed (Month, Dey, Year)

ss of person who completed cause of death (Item 23a) (Type, Print)

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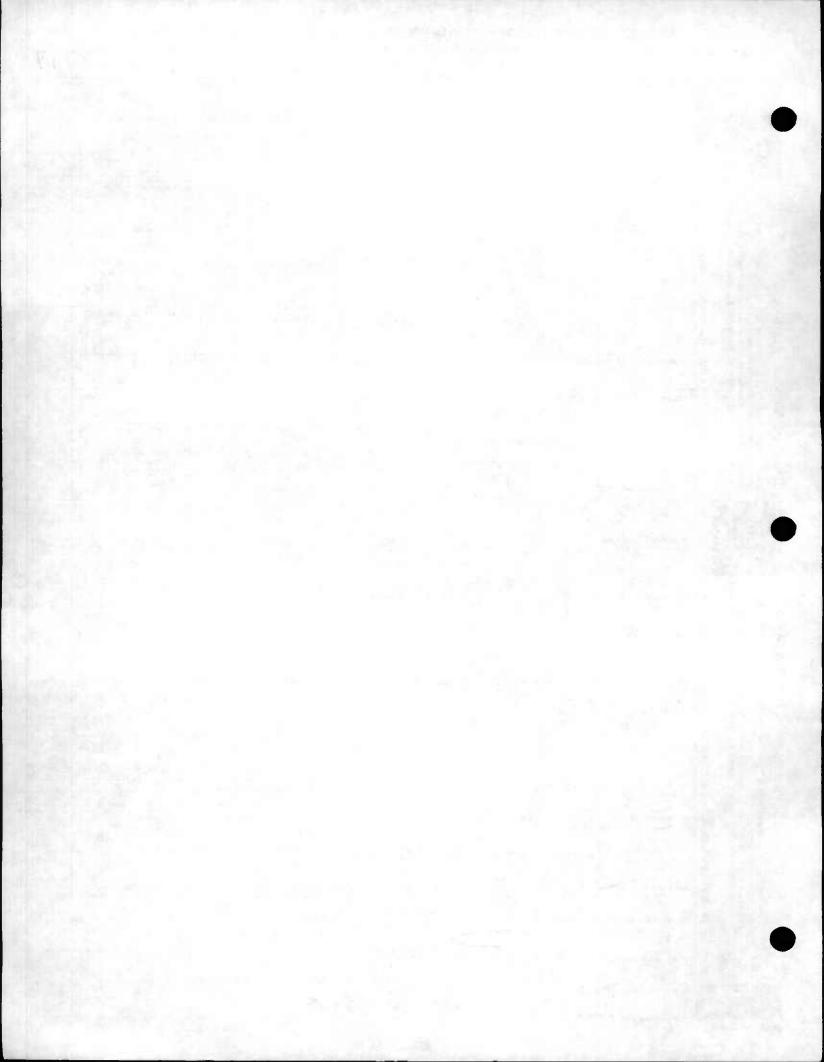
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22047 Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Daath Day Month **Physician** Margaret Callahan 11, July 2000 8:00 A.M. /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4016 Bellwood N/AAvenue Baltimore 8. Deta of Birth (Month, Day, Year) 9/16/1902 Birthplace (Stata or Foraign Country) 5. Social Security Number If Undar 1 Yaar 7. Aga (In yrs. lest birthday) **Funeral** Days Hours Months 1 M 200 97 216-46-2451 Director Maryland Usual Residence of Decedant with the Meryland 10a. Stata 10c. City, Town or Location 10d. Instda City Limits Nerns 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at MD N/A 1 X Yas 2 □ No Baltimore Director 10a. Street and Number 10f. Zip Code 10g. Citizan of What Country? permit. Pagas 1 and 2 should be filed within 72 hours efter death with Department of Health and Mental Hygiene. Important if I fam 27 is marked other than *--- any Injury or other traumeth. 4016 Bellwood Avenue 21206 U.S.A. Funeral 13. Was Decedant of Hispanic Origin? (Specity Yas or No-If Yas, specity Cuban, Maxican, Puarto Rican, atc.) 14. Raca - Amarlcen Indian, Black, Whita, atc. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yes 2₹2No If Yas, Give Year or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 ☒ No Specify: White Specify: É 3 XWidowed 4 ☐ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) Cottege (1-4or 5+) Homemaker Own Home 17. Fether's Nema (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) John McGuire Mary Harmeyer 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Numbar, City or Town, Stata, Zip Code) Dorothy Callahan/Daughter 4016 Bellwood Avenue Baltimore, Maryland 21206 20a. Method of Disposition 20b. Ptaca of Disposition (Nama of camatary, cramatory or other place) Date 20c. Location - City or Town, Stata 1 ☑ Burial 2 ☐ Cramation 3 ☐ Ramovat from Stata Holy Redeemer Cemetery 7/15/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 22. Name end Address of Fecility John C. Miller Inc. Signature of Foneral Service Licensee 6415 Belair Road Baltimore, Maryland 21206 23a. Part1. Enter the disease, or combinations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helicit failure. List only one cause on each line. Approximata Intervat Batwaan Onsat and Death **Physician** CONGESTIVE HRANT FAILURE /Medical Immediate Cause (Final disaase or condition rasulting in daath) **Examiner** Due to (or as a consaquanca of) Examine The law requires that the death cartificete be axecuted Sequentially list conditions, if any, laading to immadiata causa. Entar Undarfying Cause (Diseasa or injury that initiated avants rasulting in death) Last Due to (or as e consequance of): ed by the ettending physician dateched for use as the buria Box 68760. Physician/Medical Dua to (or as e consequance of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 □ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed by 24b. Wara autopsy findings available prior to completion of causa of death? 24a. Was an autopsy performad? cartificate has 2 00 1 Yas 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifica completely filled in by the funeral director, 25. Was casa referred to medical axaminar? Medical Certification: To Be 26. Placa of Death (Chack only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatiant 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☐ Nursing Homa 6 ☐ Othar (Specify) 1 Yas 2 N 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 27. Menner of Death 28d. Dascribe how injury occurred 5 Pending invastigation 1 Staturat 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Streat and Number or Rural Routa Number, City or Town, State) 4 - Homicide Striftying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

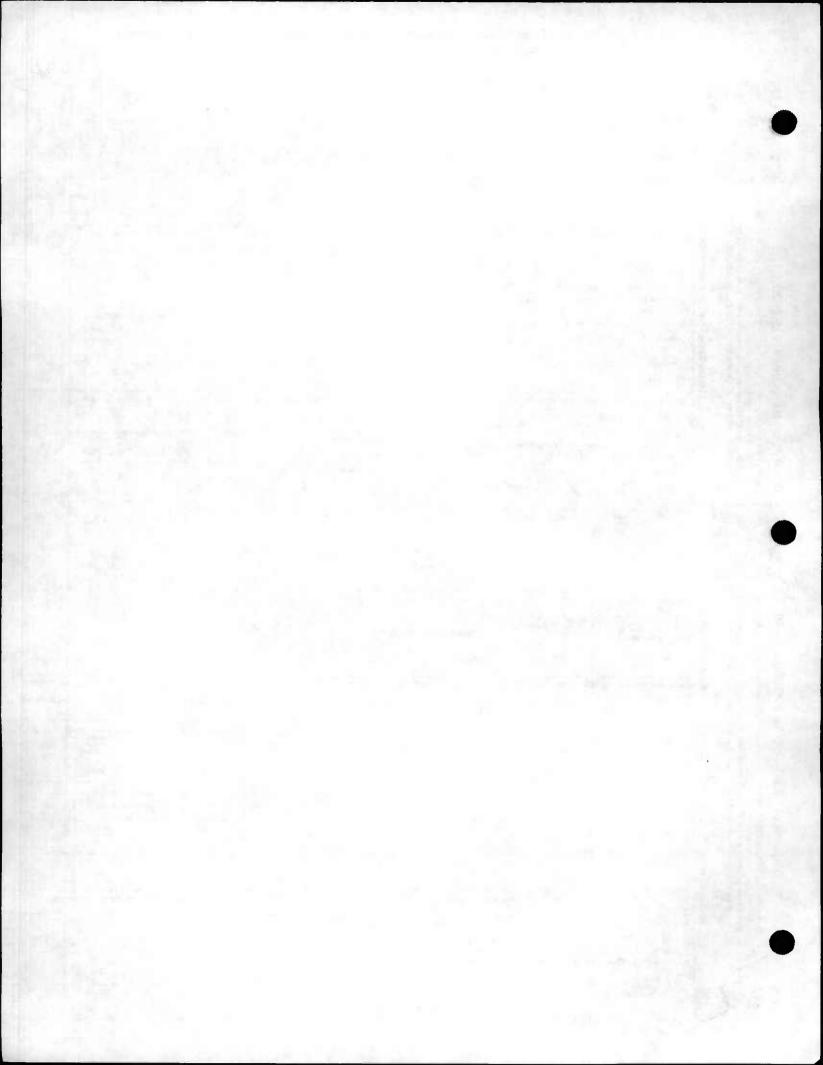
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Cartifian and mannar stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of Cortif 29c. License number 8662 00 B-8 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Dr. William Goldiner 5901 Harford Rd Suite B Baltimore MD 31. Data filed (Month, Day, Year) 32. Registrer's Signature State JUL 12 Registrar ZUUU

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22048 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Month Day **Physician** Elaine Davis July 2000 06:51 P.M. 04 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 912 High Street Cambridge Dorchester If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) **Funeral** Days Min. 1 M 2 KF Months Hours 48 Yrs. 215-64-9261 Director Oct 25, MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits hams 23a or 28a-f show 1PYAS 2 No Director MD Dorchester Cambridge 10e Street and Number 10f Zin Code 10g. Citizen of What Country? 912 High Street Ext. 21613 United States Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Maxican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. be filed within 72 hours after 1 Yes 2 No If Yas, Giva Year or Dates: 1 Never Married 2 Married ò Maryland 21215-0020 1 Yes 2 No Specify þ Specify: Black 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Restaurant al Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) 10 Waitress 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be of Health and Mental P Hem 27 is marked of r other traumatic ever Benjamin Davis Bessie Davis Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Routa Number, City or Town, State, Zip Code) James Pinder, Jr.-Son 312 Crusaders Rd Apt. 201 Cambridge, MD altimore, 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Mathod of Disposition Data Department of I Jul 11 1 Burial 2 Cremation 3 Removal from State 8 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Pk. 2000 21. Signature of Funeral Service License 22. Neme end Address of Facility Smith & Williams Funeral Home, 2818 East Baltimore Street Baltimore, MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediata Causa (Final disaasa or condition resulting in death) a Atherosclerotic Cardiovascular Disease Examiner Due to (or as a consequenca of): Examiner The law requires that the death certificate be executed the burial-tran Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of) for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown Morbid Obesity ð 90 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed certificate has 12 Yes 2 No 1 Yes 2□ No of Vital Attanding Physician: director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital; 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Opther (Specify) To 1 Yas 2 No this funeral Certification: 27, Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Affert Division 5 Pending invastigation 1 Natural 2 Accident I or Attanding after death. I Director: Af ed in by the fu 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide filled in Hospital To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, date and placa, and due to the cause(s) and manner as stated.

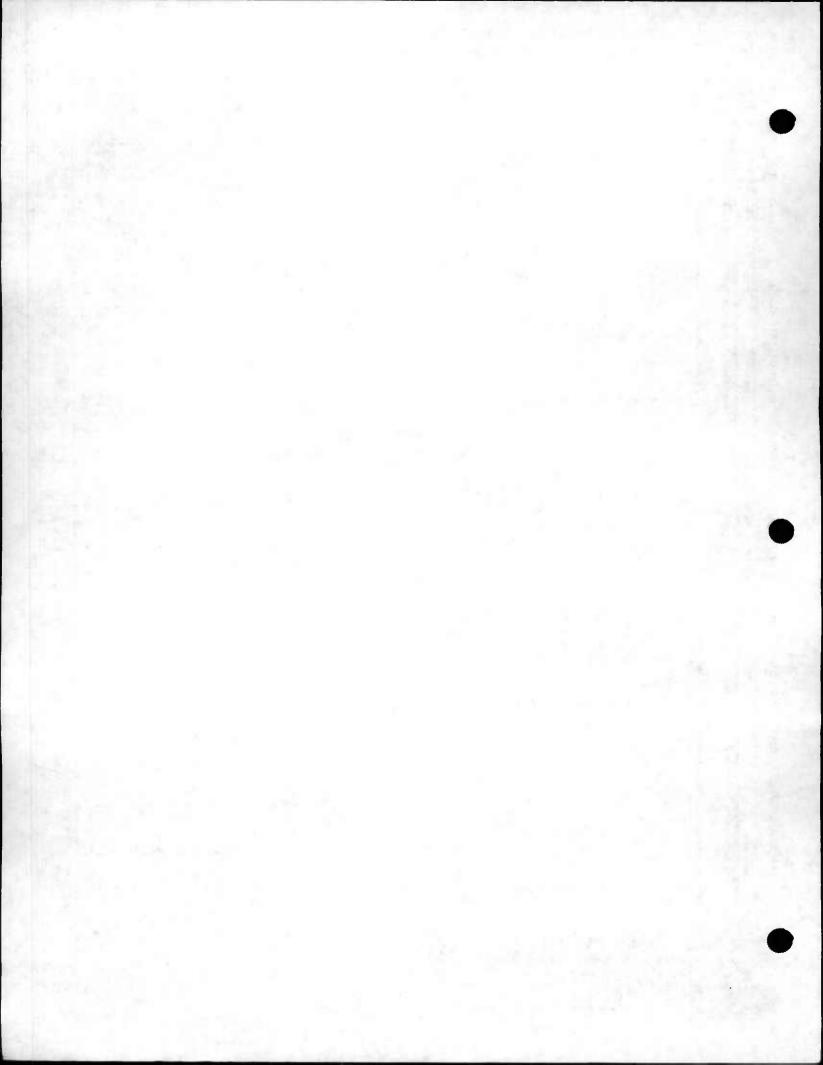
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifian 29c. License number O.C.M.E. July 6, 2000 MP 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) W Stephen S.
31. Date filed (Month, Day, Year) Radentz 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature State Registra



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year **Physician** Amelia Lucy Davis 9 July 2000 12:45 PM /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Catonsville Commons Catonsville Baltimore If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 M 2 F Director Sep 18, 1923 Virginia 228-34-9788 nce of Dece the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Wedical Examinar must be notified at 1 X Yes 2 No Maryland Baltimore Director N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 1110 Carroll Street U.S.A. 21230 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - American Indian, Black White etc. after 1 ☐ Yes 2 ☑ No If Yes, Give Yaar or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 ified within 72 hours at I Hygiene. other then "natural", or 1 Yes 2 No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home le marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked other any Injury or other traurmatic event Rate. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Jones Lucy (Unknown) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Smithson / son 540 S. Bentalou Street, Baltimore, Maryland 21223 20b. Place of Disposition (Name of 20c. Location - City or Town, State Data 20a. Method of Disposition cemetery, crematory or othar place) 1 Suriat 2 □ Cremation 3 □ Removat from State 7/11/2000 Elkridge, Maryland Meadowridge Mem. Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funaral Sarvice License 22. Name and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 Approximata Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. **Physician** /Medical SMALL CELL CANCINOMA LUNG Immediate Cause (Final disaase or condition resulting in death) Examiner Examine Sequentiatly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contributa to the causa of death? Ö the Part II. Other stgniftcant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 tonknown ۵ Records, ģ 24a. Was an autopsy performed? 24b. Were autopsy tindings available prior to Completed complation of cause of death? 1 Yes certificate of Vital 25. Was case referred to medical examiner? Be 26. Placa of Death (Check only one) Hospital: Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Other: P 1 Yes 21 No 1 Inpatient 2 ER/Outpetient 3 DOA To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After t completely filled in by the funera 27. Manner of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined Location (Streat and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide edicai 112 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certif 29c. License number 30. Name and address of person who completed cause of death (first 23a) (Type, Print) YIE d Day 32. Registrar's Signature State 2000 Registrar

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death **Physician** 6:35 PM E. KEFSE DUKES JUL. /Medical 4a Facility Name (ff not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOWARD COUNTY GENERAL HOSPITAL HOWARD COLUMBIA If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 222-22-5384 7. Age (fn yrs. last birthday) 77 Yrs. 8. Date of Birth Aug 31, 1922 Birthplace (State or Foreign Country) **Funeral** Days Months 1 □ M 2 □ F Director Delaware Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 25a-f show 1 Yes 2 No Director MD Howard Columbia 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 8 6 23a 6336 Cedar Lane U.S.A. 21044 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygierie. snt: if Item 27 Is marked other than "natural", or its 1 ⊠Yes 2 No If Yes, Give 43-46 Yaar or Dalas: 1 ☐ Nevar Married 2 ☑ Married 1 ☐ Yes 2 ☐ No Specify þ Specify: white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) college professor education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surnama) John R. Dukes Mariam Hastings 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) Harriette Dukes, wife 6336 Cedar Lane, Columbia, Md. 21044 20b. Place of Disposition (Nama of cemetary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Department of It Important: If ite any injury or of 1 ☐ Burial 2 MCremation 3 ☐ Removal from State Baltimore/Washington Crem. 7/8/00 Laurel. Md. 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facility Homes, Inc. 21. Signature of Funaral Sarvice Licensee 5555 Twin Knolls Rd., Columbia, Md. raus Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) VENTRICULAR FIBRILLAMON MMEDIATE Examiner CORONARY ARTERY YEARS The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): use as the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Stophylococcus amen ves prater Completed by 24b. Were autopsy findings evailable prior to 24a. Was an autopsy performed? completion of cause of death? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To funeral 27. Manner of Death 1 Death 28b. Time of 28d. Describe how Injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 5 Pending investigation 24 hours after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) completely filled in by 4 Homicide

P.O. Box 68760, Records, of Vital or Attending Division

Baltimore, Maryland 21215-0020

within 2 To the

29a. Certifier

(Check only

29b. Signature and title of certifier

State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

JOSEPH GIBBOUS, MI 9501 OLD ANN AB JOSEPH GIBBONS, MA

the vo

29c. Licanse number 138296

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

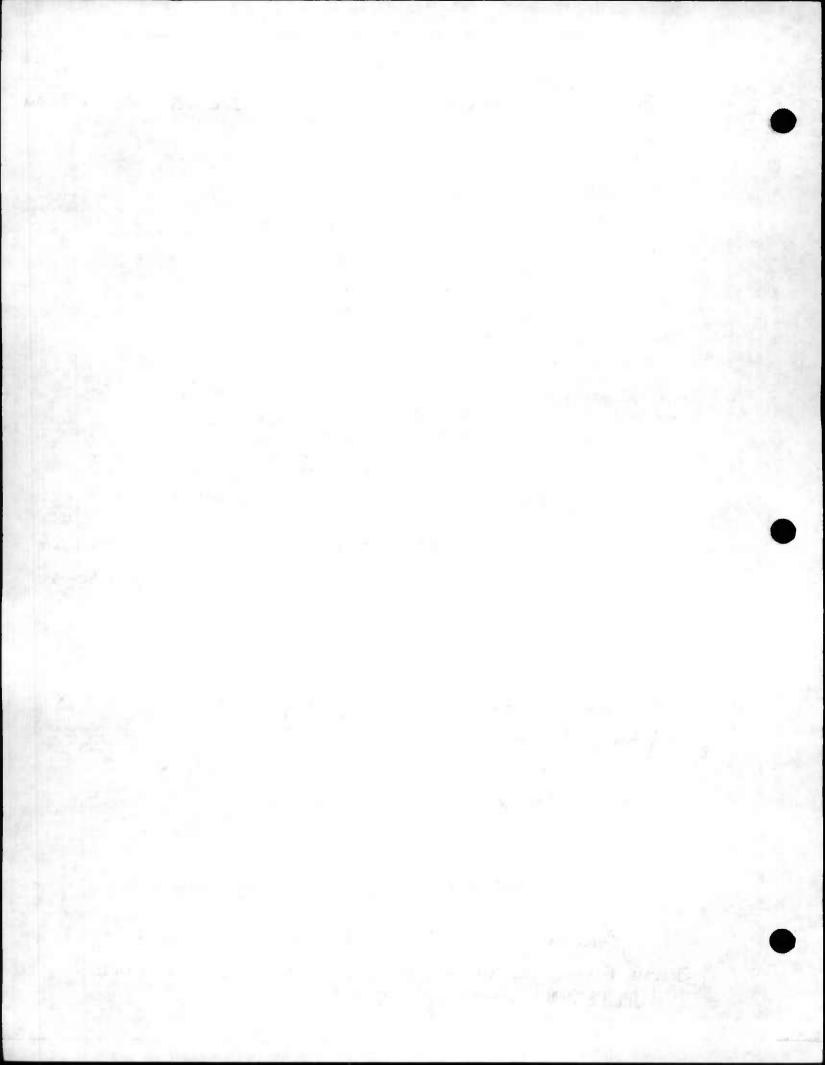
29d. Date signed (Month, Day, Year)

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ANNAPORIS AD, ELLICOTT CITY, MD 21042

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Hospital

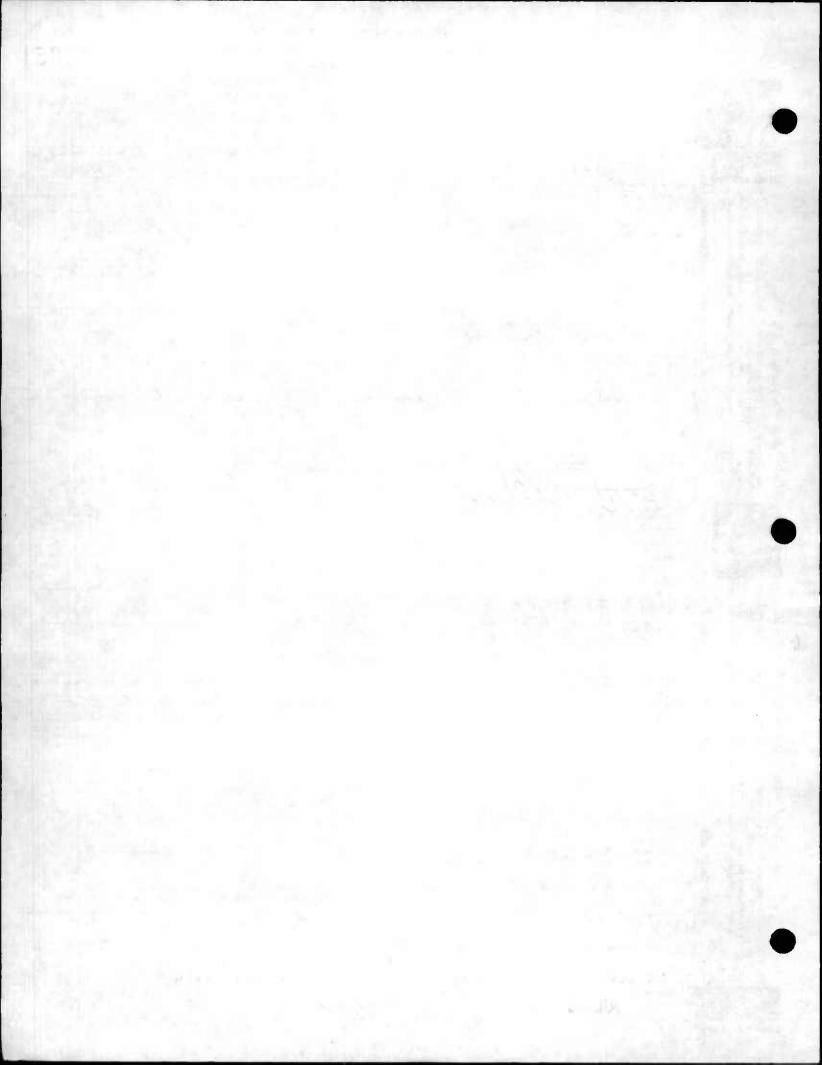


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State of Maryland / Department of Health and Mental Hygiene

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neral ector	5. Soci	al Security 1	Number	6. Sex	7.	Age (In yrs. I	ast birthday) Yrs.	If Unde Months	r 1 Year Deys	If Under 2 Hours	4 Hrs. Min.	8. Date of B. (Month, D. 1/26/1	irth lay, Year)	9. Birth Cou Mary	place (State or Foreigntry) Land
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rector			N/A				timore	Cation							10d. Inside City Limi 1200 2 □ N
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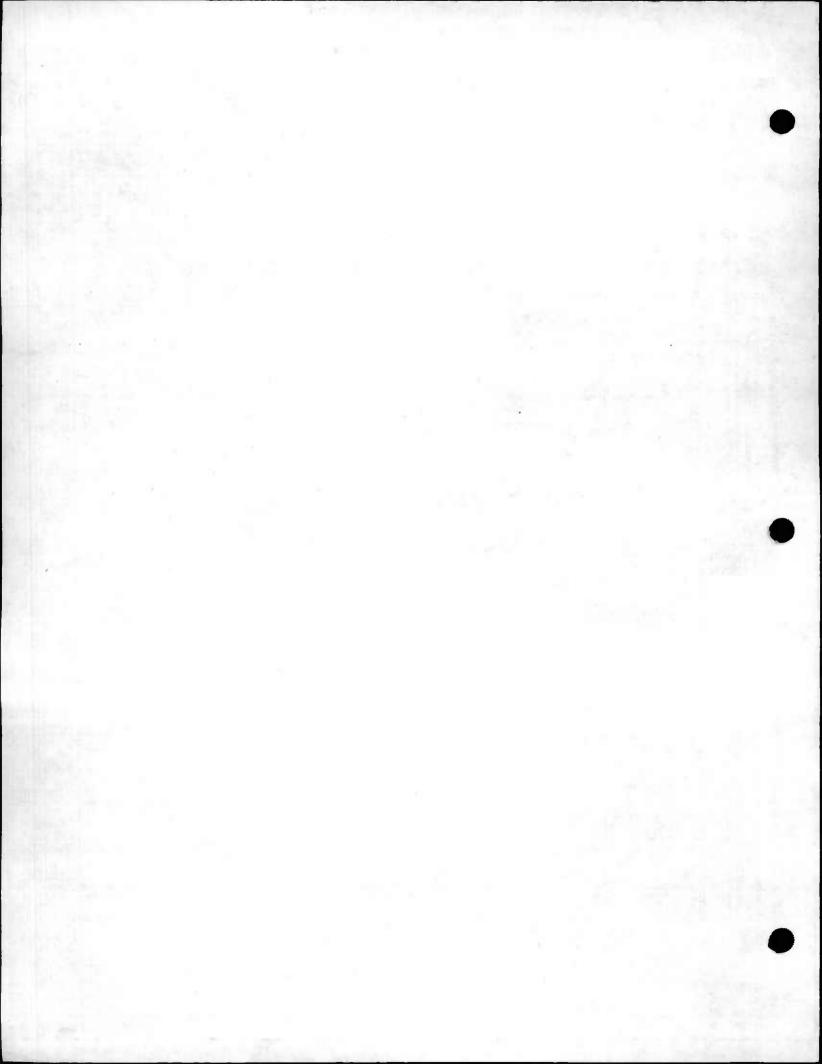
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middla, Last) 2. Data of Death 3. Tima of Death **Physician** Herman 6 12:32 AM EVerett 00 10 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Baltimore Affairs Medical Kutimore eterans Center If Under 24 Hrs. 8. If Under 1 Yaar 6. Sex Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) Data of Birth (Month, Dey, Year) **Funeral** 1 M 2 F Days 71 Yrs. 242-32-1592 Director 05-16-29 NC Usual Residence of Dacedant filed within 72 hours after death with the Maryland 10a Stata 10b. County 10c. City, Town or Location 10d. insida City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiene. Important: If Item 27 is marked other than "natural; or Itema 23a or 28a-f show any folury or other treumatic event, the Madical Eminitational continued any louds. 1 Vas 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21218 2600 Kirk Avenue Funeral 12. Was Decedent Evar in U,S. Armed Forcas? > N ⊠ Yas 2 □ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, etc.) 14. Race - American Indian. 11. Meritel Sfatus Black, Whife, atc. 1 Nevar Merried 2 Married 21215-0020 Specify: Black 1 ☐ Yas 2 ☐ No Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highest grade completed) Elamenfery/Secondary (0-12) Collega (1-4or 5+) Bethlehem Steel Co 8th Grade NA Laborer Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Nama (First, Middla, Maiden Sumama) Weston Everett Elizabeth 19e. informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Routa Number, City or Town, Stete, Zip Code) 2600 Kirk Avenue Baltimore, Maryaland 21218 Eunice 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Steta 1 월 Burial 2 ☐ Cremation 3 ☐ Removel from State Garrison Forest VA Cem. 07-14-2000 Owings Mills 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funerel Service Licenses 22. Nama and Addrass of Facility Baltimore, Maryland 21202 WM.C. March FH 1101 E. North Avenue ano Approximata Interval Between Onsat and Death 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediata Causa (Final disaese or condition resulting in death) /Medical lung carcinoma Examiner Dua to (or es a consequance of) Physician/Medical Examiner Sequantially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or injury that initiated evants rasulting in daath) Last Dua to (or as a consequence of): The law requires that the death certificate be east Box 68760. 40 Dua to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yes 2 No 3 Probably 4 Unknown Records, þ 8 24b. Wara autopsy findings available prior to complation of causa of death? Be Completed 24a. Wes an eutopsy 1 Yas 2 X No this certificate 2□No 1 Yas Division of Vital 25. Was casa rafarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) 1 Yas 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 27. Manner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred i or Attending P after death. Director: After I 5 Pending invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Sulcida 281. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28a. Place of Injury · Af homa, farm, streat, factory, office building, atc. (Specify) ă 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely tilled it Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, date and place, end due to the cause(s) and manner es stated.

| Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the tima, date and piece, and due to the course of the time. 29e. Cartifier (Check only one) hiner: On the basis of examination and/or Investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) 29b. Signatura and titla of 29c. Licensa number 29d. Date signed (Month, Day, Year) 30. Name and address/of p mplated causa of death (Item 23a) (Type, Print) 10 21261 (+ seen 100 32. Registrar's Signature 31. Data filed (Month, Dey, Year) State JUL 12 2000

DHMH 16 Rev 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22053 Certificate of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month W. Entwistle Stuart June 28 2000 10:30am 4c. County of Death 4b. City, Town, or Location of Deeth 4a Facility Neme (If not institution, give street and number) Baltimore Gilchrist Towson Center If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Months Deys 12 M 2□F 215-24-7942 77 Yrs. MD July 26, 1922 Usuel Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 Yes A No 10g. Citizen of Whet Country? 10f. Zip Code 21210 10e. Street and Number 6013 Ridge Road Hunt 12. Wes Decedent Ever in U,S. Armed Forces? 1 Yes 2 No Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. 11. Merital Status Bleck, White, etc. 1 Never Merried 2 Married White 1 Yes 2 No Specify: ff Yes, Give Yeer or Detes: WW II Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Engineer Environmental 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Nellie Whalley Alfred Entwistle 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Cockeysville, MD 21030 Stuart D. Entwistle -10928 Powers Avenue son 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 20b. Piece of Disposition (Neme of 20c. Location - City or Town, Stete Dete cametery, cremetory or other ptece) 6/29/00 Towson, MD Hilltop Service Corp. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Ruck Towson Funeral Home, I 1050 York Road, Towson, MD Dennis C. Carroll, per DVR 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Intervel Between Onset end Deeth Immediate Cause (Finel disease or condition resulting in death) 3 mis Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last cunc Due to (of a) a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Dtd tobacco was contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings 24a. Wes an autopsy performed? eveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 1 Yes 26. Plece of Deeth (Check only one)

Physician /Medical Examiner

Physician

/Medical

Examiner

MD

Directo

Funeral

Be Completed by

Funeral

Director

r than "natural", or Hems 23a or 28a-f ahor the Medical Examiner must be nothled at

filed within 72 hours after Hygiene.

other

permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe eny injury or other treumatic event, page.

as the burial-trensit esn o signed by 2 should be hes page

the deeth certificate be executed

The law requires that

Hospital or Attending Physician:

of Vital

Division

Physician/Medical Examiner þ Be Completed After this certificate funeral director edical Certification: To s after death. the

25. Was case referred to medical Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence Other 1 Yes 2 No 27. Manner of Death 1 Neturel 28c. tnjury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Pieca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, State) 4 Homicide

29a Certifier

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and menner as stated.

Zi Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated.

29b. Signeture and

od

31. Date filed (Month, Day //e

29c. License number

BMC

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29d. Dete signed (Month), Dey, Year) 28/00

Baltimore MD

State

filled in by

within 24 hours a To the Funeral C completely filled

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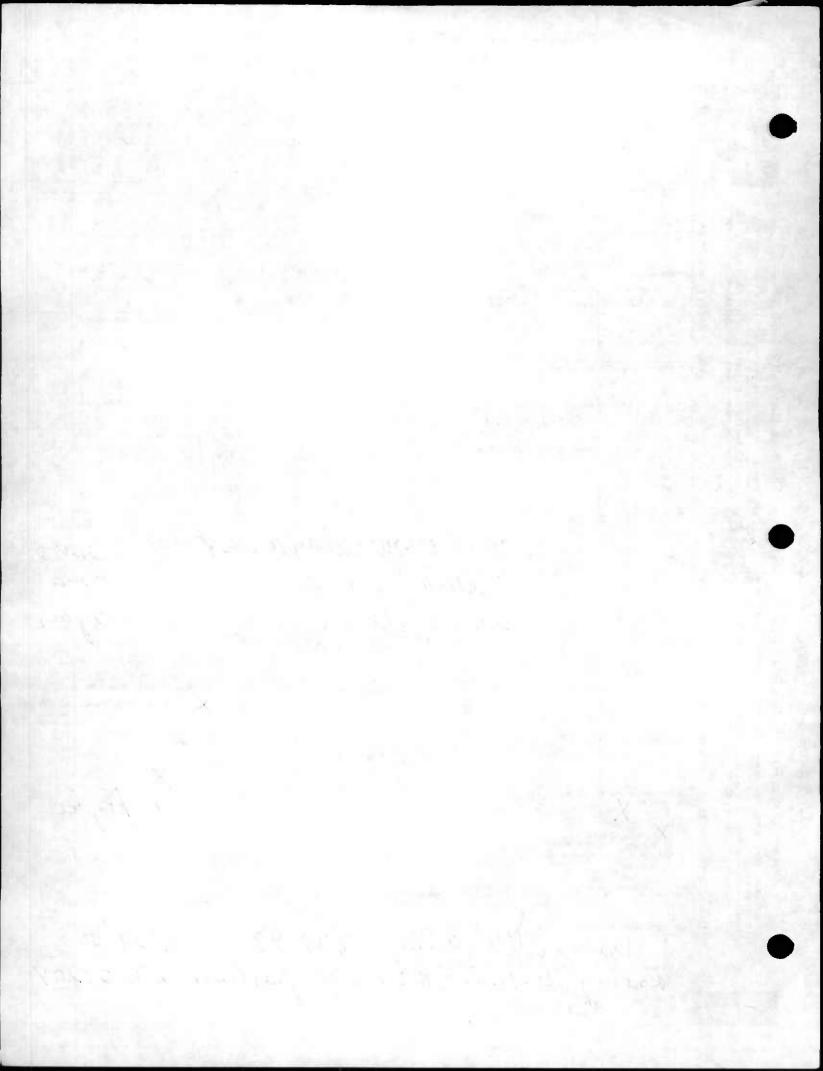
Registrar

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32. Registral's Sign

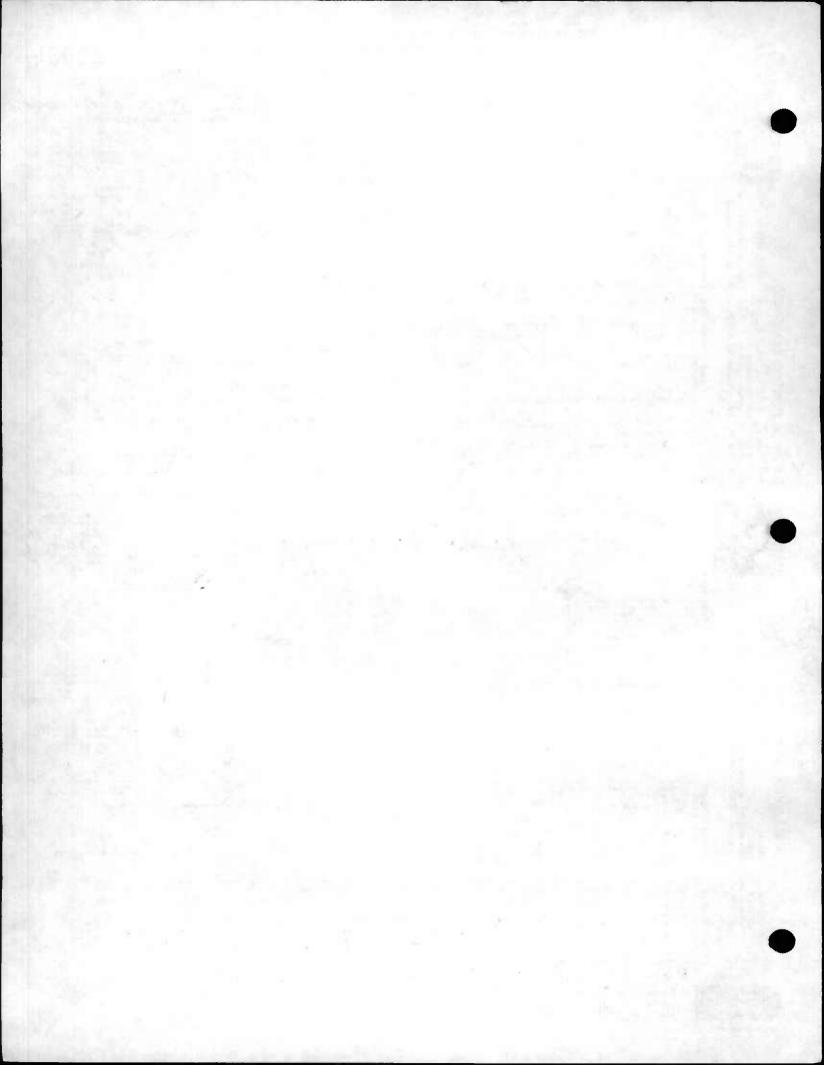


Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

22054 amend item 26 per phys. G785 7/12/00 yg Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Year Month **Physician** 10:40 AM -NES OULISE. WITON 2000 cel /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner NIA SACTIMORE If Under 1 Year If Under 24 Hrs. Dete of Birth (Month, Dey, 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Months 1□M 2XF 212-34-136 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at 1 Yes 2 No Sal II more Directo herne 23a or 28a-f 10g. Citizen of Whet Country? 10e. Street and Number 10f. Zio Code 4514 2/2/4 Funeral scale 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 11. Merital Stetus hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Merried 8 Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ BLACK 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 al Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) HOUSE WITE 4/2. 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be is marked of UNKNOWN 2 EL MUNN 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Reletionship (Type, Print) / Health i med. 212/4 LUCTON, I doubt HTER Woodale THERNICE 70 alton Baltimore, 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) Dete 20e. Method of Disposition 20c. Location - City or Town, Stete Department of H important: If its any injury or of 1 Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Temore Tlat'llem 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility AROLINE 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between **Physician** /Nedica, Immediete Cause (Final disease or condition resulting in death) LAGRINET Physician/Medical Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or frijury that initiated events resulting in death) Last Due to (or as a consequence of): the Due to (or as a consequence of): esn P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23h. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24a. Wes an eutopsy performed? Completed After this certificate has 200 No 1 Yes 1 ☐ Yes 3 No Division of Vital 25. Wes case referred to medical examiner? Medical Certification: To Be 28. Place of Deeth (Check only one) 1 Yes 2 No Hospitel: 1 ☐ Inpatient 2X ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Secretary s efter death.
ii Director: After this od in by the funeral d 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Netural or Attending 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 ☐ Accident To the Hospital or Attenwithin 24 hours efter dea To the Funeral Director completely filled in by the 6 ☐ Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide to Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) and menner stated. 29a, Certifier (Check only one) 29b. Signeture end title of certifier. 29c. License number 29d. Date signed (Month, Dey, Year) 0054911 M.D. erson who completed cause of death (Item 23a) (Type, Print) B-ENICH 4940 FAST 30 Name and ed EASTERNAVE. BALTIMORE UND 21224 ODRIGO 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUL 12 ZUUU Registrar



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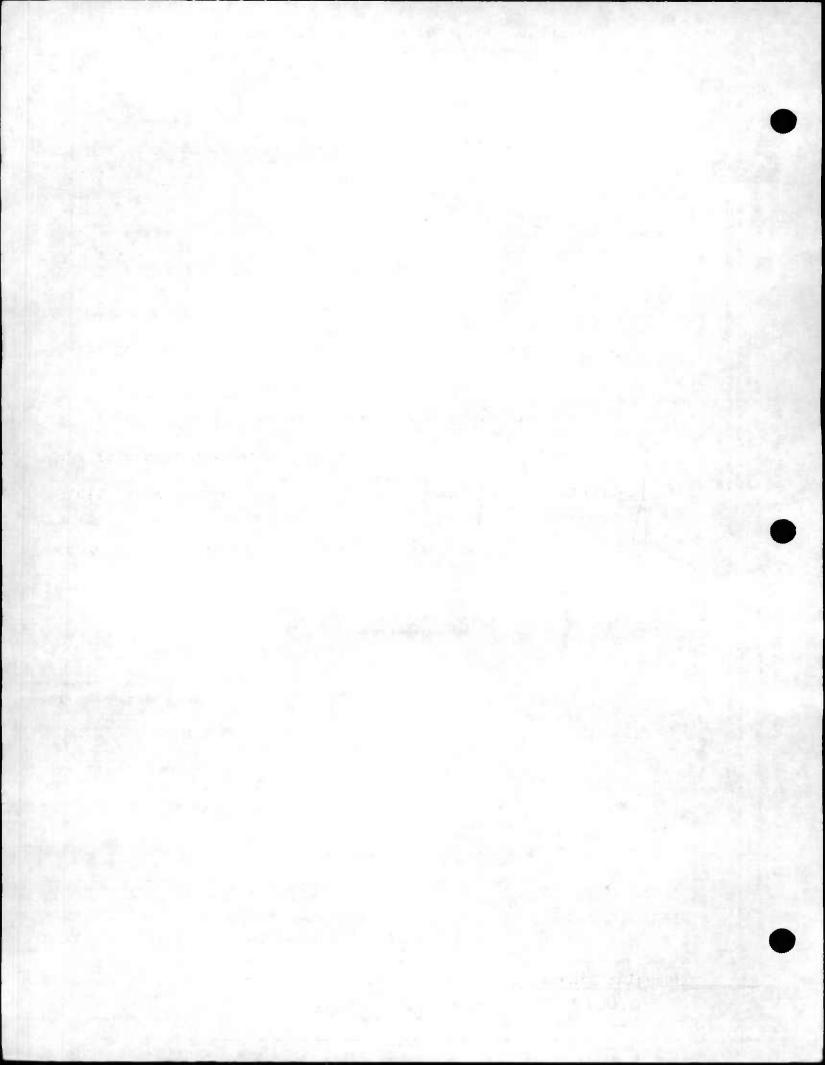
State of Maryland / Department of Health and Mental Hygiene 22055 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Data of Death Dev Yee **Physician** July 10:17AM Frank Annie Mae 07 2000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, giva street end number) 4c. County of Deeth Examiner Union Memorial Hospital Baltimore 8. Dete of Birth (Month, Day, Year) 04 22 7. Age (In yrs. lest birthdey) If Under 1 Year | If Under 24 Hrs. 9. Birthplece (Stete or Foreign Country)
S • C • 5. Social Sacurity Number **Funeral** Deys Months Hours 1 M 2 X F Yrs. 24 Director 76 237-52**-**9240 Usuet Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits if then "natural", or Items 23s or 28s-f show the Medical Examiner must be notified at TX Xes 2 □ No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 21211 1004 West 41th Street Funeral Raca - American Indian, Bleck, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Pages 1 and 2 should be filed within 72 hours efter ment of Health and Mentel Hygiene.
ant: if item 27 is marked other than "natural; or he with yor other traumetic event, in Medical Entering Inc. 1 Yes 2 No If Yes, Give 1 Never Merried 2 Merried Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 2 Specify: If Yes, Give Yeer or Detes: 3 Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest greda completed) 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) City Hospital 9th grade Supervisor 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Tomasina Murray 2 Zin Fox 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 834 Glenwood Ave, Baltimore Md 21212 Sylvia Seymour-Daughter altimore. 20b. Plece of Disposition (Neme of camatery, crametory or other pleca) 20e. Method of Disposition 20c. Location - City or Town, Stete Dete permit. Pages 'Department of H Important: If the any injury or of Removal from Stete
4 Donation 5 Other (Specify) Druid Ridge Cemetery 7/13/00 Pikesville, Md 22. Name end Address of Fecility
March F/H West of Funeral Service Licens 21. Signati 21215 4300 Wabash Ave, Baltimore Md iter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, heart failure. List only one cause on each line. Approximete Intervet Between Onset and Deeth **Physician** immediate Dause (Final disease or condition resulting in death) /Medical interstial pulmonary fibrons Examiner Examiner bunal-transit be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es e consequence of): physician s the buriel 68760. Physician/Medical Due to (or es e consequenca of): The law requires that the death certificate Box (signed by the ai Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? o 1 Yes 2 No 3 Probably 4 Unknown 0 Records, þ 24b. Wara autopsy findings available prior to completion of cause of deeth? 24a. Wes an autopsy performed? Completed page 2 1 Yes 2 No 1 ☐ Yes 2 1 No certificate Division of Vital Physician: Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Tyes 25€No 1 MInpatient 2 □ ER/Outpatient 3 □ DOA this funeral 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury at Work? 28d. Describe how tnjury occurred 5 Pending Investigation or Attending 1 Neturet 1 Yes 2 No 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Pleca of Injury - At home, ferm, streat, factory, offica building, etc. (Specify) 3 4 Homicide filled in 12 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. Medical 29e. Certifier completely (Check only one) within 2 To the 29b. Signature end titla of certifiar 29c. License number 29d. Dete signed (Month, Dey, Year) M.D. AT-2438946-R Richeh Buthama July 30. Neme and address of person who completed cause of deeth (ttem 23e) (Type, Print) Buthaina Richeh M.D., 201 East University Park Way Baltimore Md 21218 31: Date filed (Month, Day, Year) 32. Registrar's Signeture State 2000 Registrar April - -2000

DHMH 16 Rev 6/95

ORIGINAL



Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Deta of Death Month Day **Physician** 27, Ernest Donald Gossett 2000 2:30 AM June /Medical 4e Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner 9548 Quarry Bridge Ct. Columbia Howard 8. Date of Birth (Month, Day, Year) Dec. 15, 1 If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 17 M 2 F Yes Director S. Carolina 249-80-0784 54 1945 Usuel Rasidence of Decedent 10e State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No MD Director Howard Columbia 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 23a or 9548 Quarry Bridge Ct. 21046 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, atc. 11. Meritel Stetus filed within 72 hours after 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: ò Baltimore, Maryland 21215-0020 1 Yes 2√ No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 54) Assembly Worker G. E. Appliances 12 permit. Pages 1 and 2 should be lis Department of Heath and Mental Hy Important: If Item 27 is merited other etcy injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Nema (First, Middla, Maiden Sumeme) Be Lawrence Lawson Gossett Madora Dawkins 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Gossett - wife 9548 Quarry Bridge Ct., Columbia, Md. 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 7/01/00 4 □ Donetion 5 □ Other (Specify) Meadowridge Memorial Pk. Elkridge, Md. 21. Signeture of Funeral Service License 22. Name and Address of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP.Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory errast, shock, or haart teilure. List only one cause on each line. Physician tmmedieta Causa (Final disease or condition rasulting in deeth) /lifed.cal Exa ... Due to (or as a consequence of): Physician/Medical Examiner or Attanding Physician: The law requires that the death certificate be executed ttending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) ant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 ☐ No 3 Probably 4 DrUnknown þ page 2 should be 24b. Wera autopsy findings eveilable prior to completion of cause of daath? Be Completed 24a. Wes en eutopsy performed? this certificate has Medical Certification: To

Records, P.O. Box 68760, Division of Vital I Director: After this od in by the funeral di To the Hospital or Attal within 24 hours after del To the Funeral Director complately filled in by the

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3 ☐ Suicide 4 ☐ Homicide 6 ☐ Could not be determined		noma, farm, street, fac	tory, office	28f. Location (Street end Numbe City or Town, State)	er or Rurel Route Number,

On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

Brive

29d. Date signed (Month, Dey, Year)

29c. License number

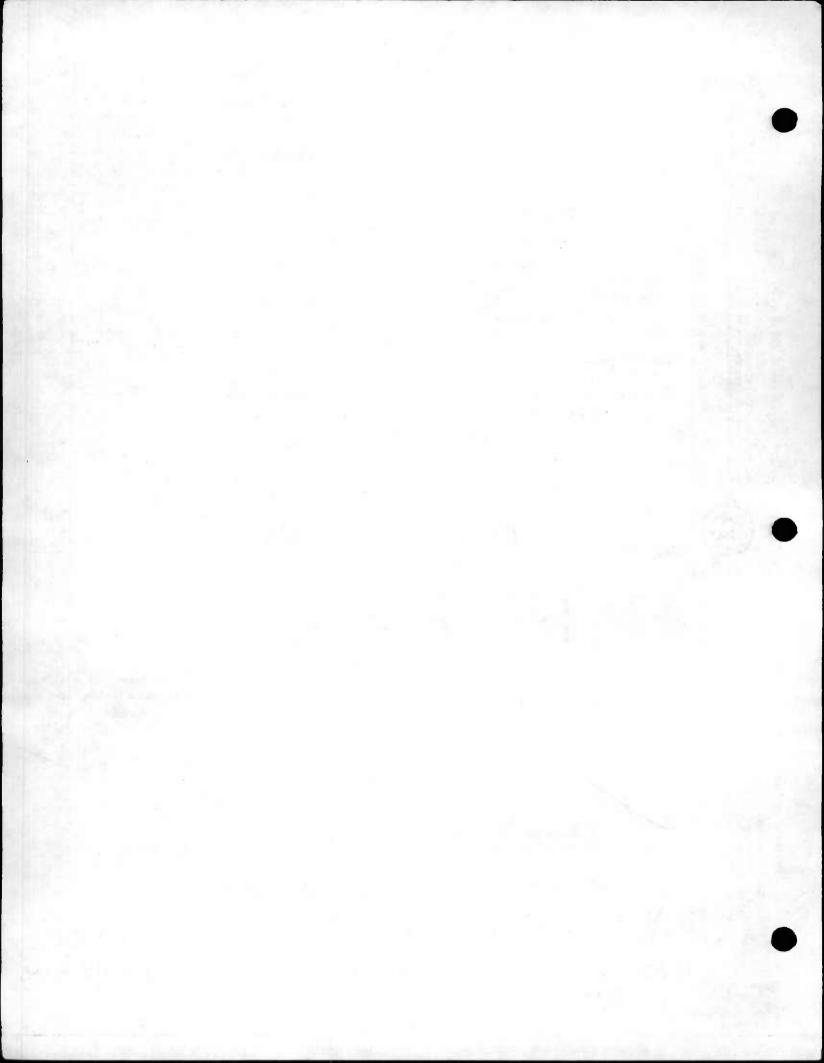
State

(Check only

32. Begistrar's Signature

Registrar

To the I within 2



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death amend item 26 per phys. G785 7/12/00 yg
1. Decedent's Neme (First, Middle, Last) Reg. No. 2. Date of Deeth Month **Physician** 21:00 Delores C. Gilmore July 8, 2000 /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 521 Donaldson Avenue Severn Anne Arundel If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 9/18/1922 9. Birthplace (Stete or Foreign Country)
Maryland If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Deys Houra 1 ■ M 2 X X 77 Yrs. Director 219-16-8610 Usual Residence of Deceden 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County MD Anne Arundel Severn 1 Yes 2 10 Director 286-1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or litema 23a or 21144 IISA 521 Donaldson Avenue Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yea or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2XXVo If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 Yes 2√No Specify: Specify: white à 3 Widowed & Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) A.A.Co. Public Schools Cafeteria 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Be Mental Elizabeth Hoffman John Jubb 2 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Reletionship (Type, Print) . permit. Pages 1 and 2 in Department of Health or Important: if them 27 is any injury or other trausons. 500-3 Victory Way, Pasadena, MD 21122 Charlene Gilmore - Daug. 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from Stete 7/11/00 Baltimore, MD Metro Crematory 4 ☐ Donetion 5 ☐ Other (Specify) uneral Service Lice 22. Name and Address of Fecility Fink Funersl Home, PA 426 Crain Hwy., SW, Glen Burnie, MD 21061 Fink Kelly Oregory 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximete Interval Between Onset end Death Ph\s ciar /Megics i Immediate Ceuse (Final disease or condition resulting in deeth) Examiner Examine physician and the burial-transit Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in deeth) Last to (or as a consequence of): Physician/Medical Due to (or as a consequence of) 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. signed by t 1 Yee 2 No 3 Probably 4 Unknown Records, þ should I 24e. Wes en autopsy performed? 24b. Were eutopsy findings available prior to Completed completion of cause of death? 2 1 No 1 Yes 1 ☐ Yes 2 ☐ No certificate Division of Vital 25. Was case referred to medical examiner? 8 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Pother (Specify) Hospitel: 1 Yea 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funera Certification: 27. Menner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Phyetclan: To the best of my knowledge, deeth occurred et the time, dete end plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the ceuse(s) and manner stated. edicai 29e. Certifier (Check only 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 46816 Curosin. 10/2000 30. Name and address of person who completed cause of death (Item 23e) (Type, Pript)

Registrar

State

RITCHE Highway

7575

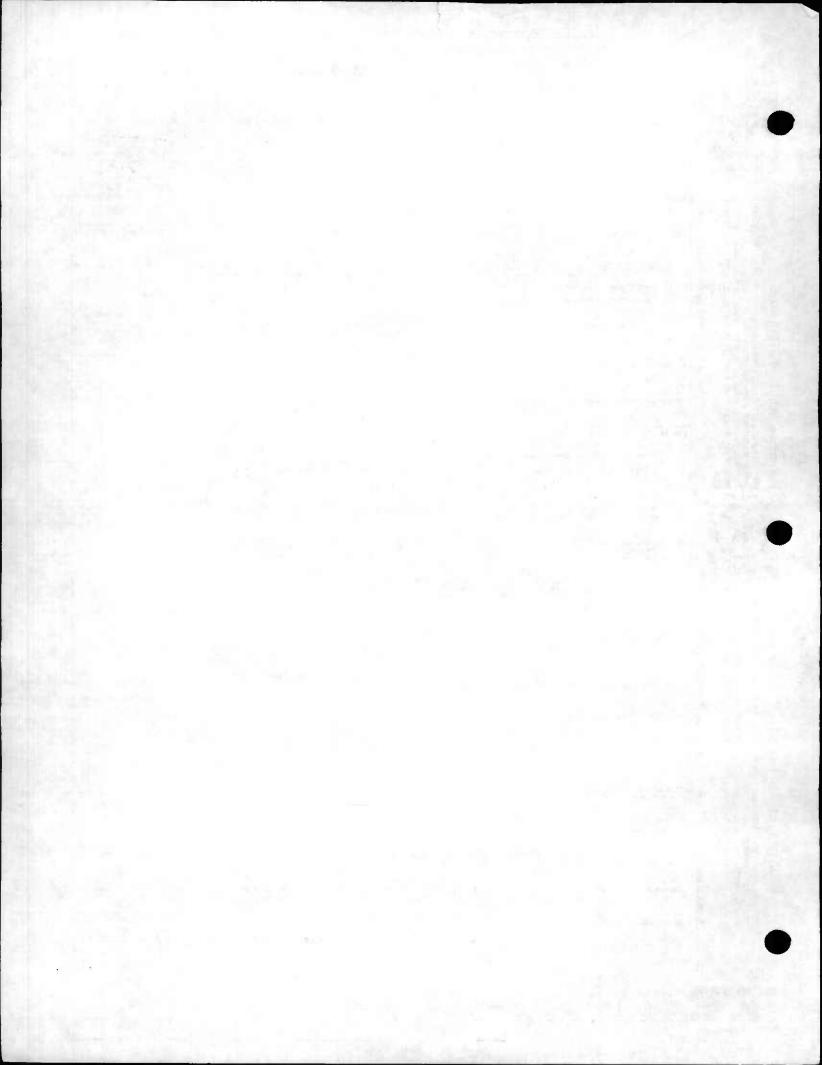
32. Registrer's Signetyre

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31. Dete filed (Month, Dey, Year)

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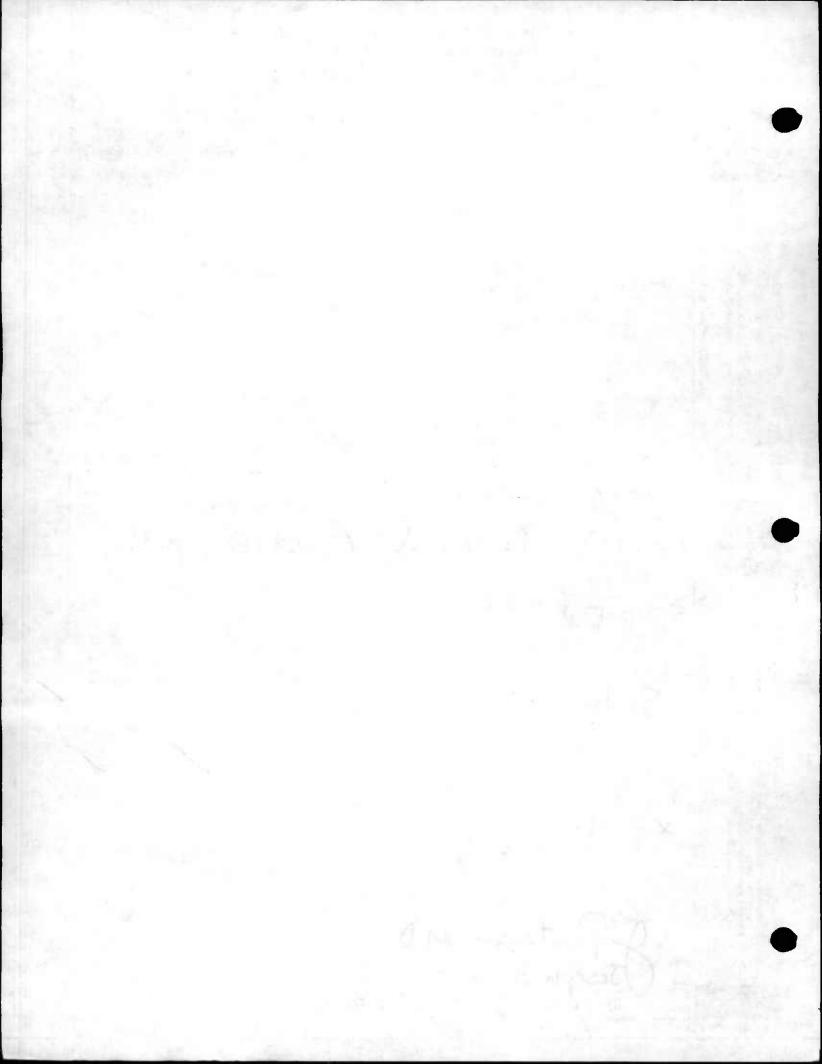


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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienen AMEND ITEM: #15 PER F.H. G785 7-12-00 WR. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death **Physician** JONES. 1310 hrs JULY ACQUELINE 08 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARMAN BALTIMORE HOSPITAL GOD 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year) 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF Director M.D. 213-52-2771 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or items 23a or 28a-f show Examiner must be notified at 1 Yes 2 No Director MD NA Baltimore 10a. Street and Number 10f. Zip Code 10c. Citizen of What Country? U.S.A. 21216 Pages 1 end 2 should be filed within 72 hours after death vient of Health and Mohall Hygiene.
Int: If Item 27 is marked other than "natural", or Items 23, ury or other traumatic event, the section from munity or other traumatic event, the section from munity. 2919 Gwynns Falls Parkway Funeral Was Decedent of Hispanic Origin? (Specity Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? Race - Amarican Indien, Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married altimore, Maryland 21215-0020 1 ☐ Yes **X**No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Administration 12th grade Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Be 2 James Archie Jones Virginia Morton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curtis Jones-Brother 1727 Ramblewood Road, Baltimore Md 21239 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Department of h Important: If its any injury or ot 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Woodlawn Cemetery 7/13/00 Baltimore Co, Md 21. Signeture of Fundami Service License 22. Nama and Addrass of Facility March F/H West 4300 Wabash Ave, Baltimore Md 21215 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest shock, or than failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** RESPITORY /Medical Immediate Cause (Final days. disease or condition resulting in death) Examiner' Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, ULTI ORGAN Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown SYSTEMIC LUPUS Records, þ 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed DIABETES. completion of ceuse of death? 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 10 1 Nation 2 ER/Outpatient 3 DOA funeral 27. Menner of Death 1 Natural 28b. Time of 28d. Describe how injury occurred Certification: 28a. Date of Injury (Month, Day Year) 28c. tnjury at Work? 5 Pending investigation Division or Attending 1 Yes 2 No within 24 hours after death. To the Funeral Director: A 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

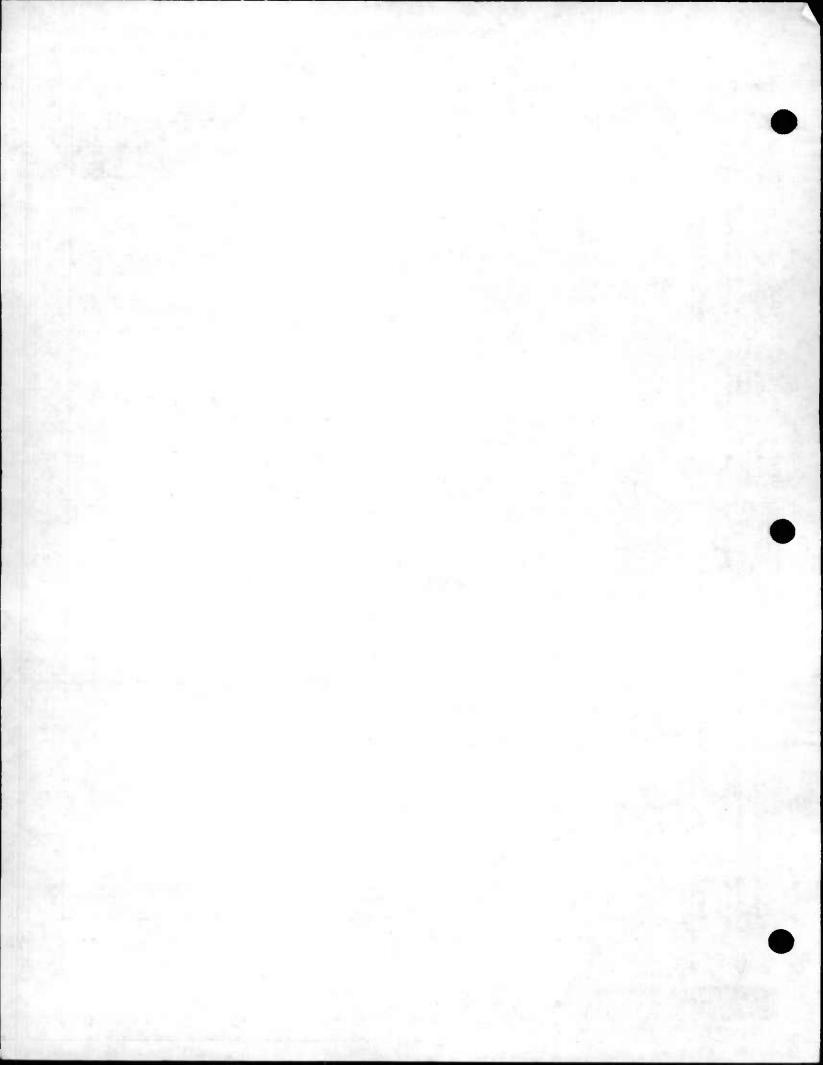
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical completely (Check only one) 29b. Signatore and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PGY-2 RESIDENT Mair Malne 2000. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
RATNA NAIR GOOD SAMARITAN Ho GOOD SAMARITAN HOSPITAL 5601 LOCH RAVEN BLUD. BACTIMORE. NAIR

State Registrar

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32. Registrar's Signature 31. Date filed (Month, Day, Year) 2000 General JUL 12

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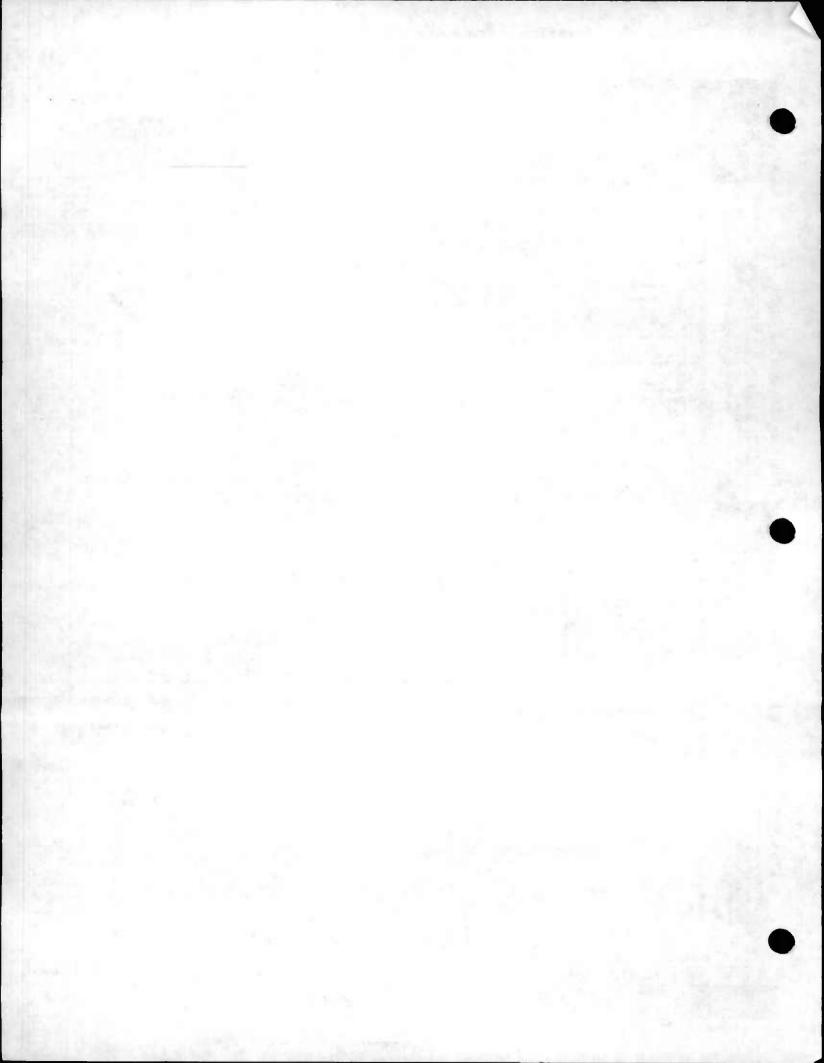


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State of Maryland / Department of Health and Mental Hygiene 22060 AMENDED ITEM #8 PER FH G785 7/12/00 AH Certificate of Death Reg. No. 1. Decedeni's Nema (First, Middla, Last) 2. Data of Death 3. Tima of Death Day **Physician** DR. R. DONALD **JANDORF** JULY 9 2000 8:20PM /Medical 4b. City, Town, or Location of Daath 4a Facility Name (If not institution, giva street and number) 4c. County of Death Examiner BRIGHTWOOD MERIDIAN NURSING CENTER LUTHERVILLE BALTIMORE If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Data of Birth] /2/1914 9. Birthplaca (Stata or Foreign MD) 1914 MD 5. Social Security Number 7. Aga (In vrs. last birthday) **Funeral** M 2□ F Days 86 Director 219-07-0235 Usual Residence of Decedent with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show MD N/A BALTIMORE N Yas 2 No Director 28m-1 10f. Zin Code 10e Street and Number 10g. Citizen of What Country? 23a or 7121 PARK HEIGHTS AVE APT. 701 21215 USA Funeral Wes Decedent of Hispenic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puerto Ricen, atc.) Race - Amaricen Indian, Biack, Whita, atc. 12. Was Dacedant Evar in U,S. Armed Forcas? 11. Marital Status hours after 1 Never Married Married Yes 2 NARMY AIR b Baltimore, Maryland 21215-0020 1 Yas 2√2 No Specify: Specify.WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Year or Datas: CORP Completed 16a. Decedant's Usuai Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) Collega (1-4or 5+) PHYSICIAN MEDICAL 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Meidan Sumeme) Be Pages 1 and 2 should be nent of Health and Mental HENRY R. JANDORF RENA is marked STRAUSS 19a. Informent's Name/Ralationship (Type, Print) 19b. Mailing Address (Straat end Number or Rurel Routa Number, City or Town, Steta, Zip Coda) permit. Pages 1 and 2 Department of Health a Important: If them 27 is any injury or other tra ELLEN JANDORF/WIFE 7121 PARK HEIGHTS AVE APT. 701 BALTIMORE, MD. 21215 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from State BALTIMORE HEBREW 7/11/00 REISTERSTOWN, MD. 4 ☐ Donation 5 ☐ Othar (Specify) Funerel Sarvice Ligur 22. Nama and Addrass of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 r complete this that caused the death. Do not enter the mode of dying, such as cerdiac or raspiratory errest, only present and the death. Approximete Intarval Batwaan Onset and Daath **Physician** nenmonia /Medical Immediata Cause (Finel disaasa or condition rasulting in death) Examiner Examiner arvinsons sician and burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, laading to immediata ceusa. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consaquance of): physician s the burial Box 68760. Physician/Medical Dua to (or as a consequence of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceusa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 28 No 3 Probably 4 Unknown signed t Records, þ 24b. Were autopsy tindings available prior to completion of causa of daath? Completed 24a. Was en autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Vital 25. Was cesa relarred to medical axaminar? Be 26. Piaca of Daath (Chack only ona) Hospital: Othar: 4 → Norsing Homa 5 □ Rasidanca 6 □ Othar (Specify) 10 1 Yas 22 No 1 Inpetiant 2 ER/Outpatient 3 DOA o this funeral 27. Mennar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred Certification: Division or Attending 5 Pending invastigation 1 / Natural 1 Yas 2 No death. 2 Accident 24 hours after deat Funeral Director: 6 ☐ Could not be 281. Location (Street and Number or Rurel Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At home, farm, streat, lactory, office building, atc. (Specify) 3 datamined 4 Homicida filled in To the Hospital **Certifying Physician: To the best of my knowledga, daath occurred at tha tima, data and piece, end due to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axaminetion end/or invastigation, in my opinion, deeth occurred at the tima, date and piece, and dua to the cause(s) and mannar stated. edicai 29a. Certifier within 24 hou To the Fune completely fi (Check only one) 29b. Signature and title of certifie 29d. Data signad (Month, Day, Year) 00 30. Nama and addrass of person who complated ceusa of death (Itam 23a) (Type, Print) B Court Ad. Baltin NA 31. Data tiled (Month, Day, Year) JUL 12 32. Registrar's Signature State Registrar

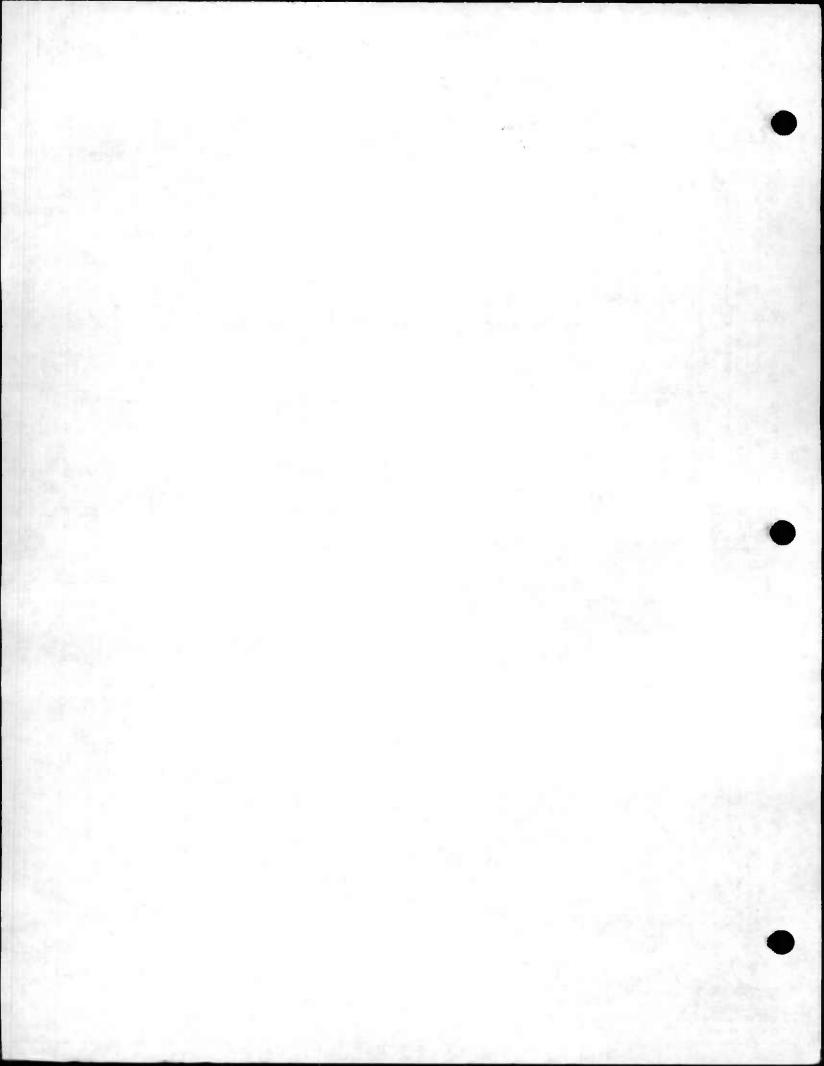
DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 00 22061

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene AMEND##17&19b PER INFMNT. G785 7-20-2000 JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth **Physician** 7000 Du Edwara /Medical 4a. Fequity Neme (If not institution, give street end number, L City, Town, or Location of Death 4c. County of Deeth Examiner o7 cmSig 0 W9 V9 oun 0650 8. Dete of Birth (Month, Dey, Year) 6. Sex 12 M 2 □ F 5. Social Security Number 7. Age (In yrs. lest birthday) Birthplece (Stete or Foreign Country) **Funeral** 215-09-9517 83 **Director** Maryland Usuel Residence of Decedent death with the Marylend permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health end Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be norified at once. 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 🏋 ☐ No Director Baltimore Catonsville 10e. Street end Number 10f. Zip Code 10g, Citizen of What Country? 615 Hilltop Road 21228 USA Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Reca - American Indian, Bleck, White, etc. 1 Never Married 37 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2X No Specify: Specify: ģ White 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 Postal Work US Postal Service 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be *Edward James Kyne Sadie Martin EDWARD J. KYNE 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code)
18 SPARROW HILL CT.
165 Hilltop Road, Catonsville, Maryland 21228 19e. Informent's Name/Reletionship (Type, Print) Jim Kyne/Son 20a. Method of Disposition 20b. Plece of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, Stete N☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/12/2000 Baltimore, Maryland Loudon Park Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility MOU741 Witzke Funeral Homes, Inc. 1630 Edmondson Avenue, Catonsville, MD 21228 remmer 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** immediate Ceuse (Finel disease or condition resulting in deeth) /Medicai ZWK5 WK4 40419 Examiner Due to (or es e consequence of) Examiner attending physiclan end for use as the buriei-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of) Division of Vital Records, P.O. Box 68760, certificete be Physician/Medical Due to (or es e consequenca of) ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings evellable prior to completion of cause of deeth? Completed 24e. Wes en eutopsy euseuti 9 2 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Piece of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No this 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Certification: 5 Pending investigation 1 Natural al or Attending s efter death. i Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) filled in by 4 ☐ Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end piece, end due to the ceuse(s) and menner as stated.

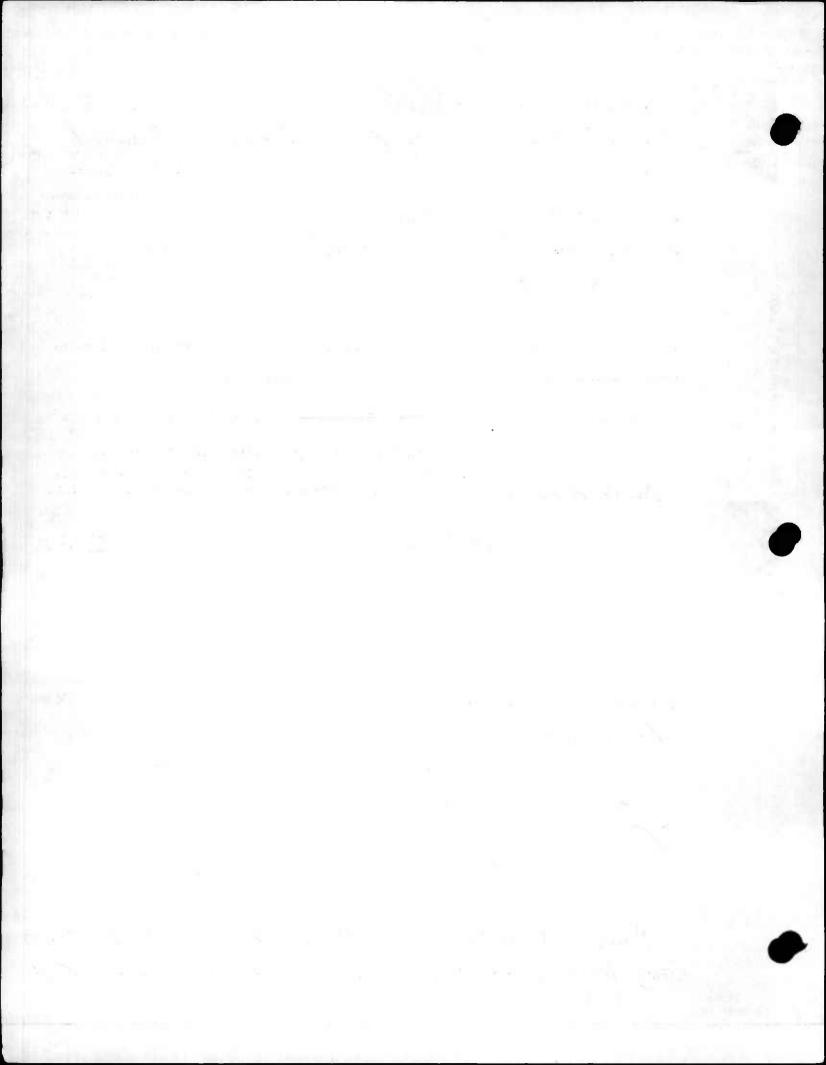
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the ceuse(s) and menner stated. (Check only 29b. Signeture end title of cartifier 29c. License number 29d. Date signed (Month, Dey, Yeer) 041617 30. Name end eddres impleted cause of deeth (Item 23e) (Type, Print)

32. Registrer's Signature

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Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Deeth 2. Dete of Deeth JOSEPH F. KAPINOS 10 PM 2000 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 5600 Knell Avenue Baltimore If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. lest birthday) 8. Dete of Birth (Month, Dey, Year) 3-17-18 Birthplace (Stete or Foreign Country) Deys Months Hours 215-10-5240 82 Yrs. Maryland Usuel Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Baltimore 1 ☑ Yes 2 ☐ No 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 5600 Knell Avenue 21206 U.S.A. 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bieck, White, etc. 1 Never Merried 2 Married 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Letter Carrier U.S. Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Frank Joseph Kapinos Anna (Unknown) 19e. Informent's Neme/Reletionship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Claire Kapinos/Wife 5600 Knell Avenue Baltimore, Maryland 21206 20e. Method of Disposition 20b. Pleca of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete ty Burial 2 □ Cremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith Cemetery 7/8/00 Baltimore, Maryland 21. Signature of Funeral Service-Licensee 22. Neme end Address of Fecility John C. Miller Inc. 6415 Belair Road Baltimore, Maryland 21206 the deeth. Do not enter the mode of dying, such es cardiac or respiratory arrest, Approximete Intarval Between Onset end Death Immediete Cause (Finel diseese or condition resulting in death) YEAR . MYELODYSPLASTIC SYNDROME Due to (or es a consequence of): Due to (or es e consequence of): Due to (or es e consequenca of) 23b. Dfd tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown

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7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar transition notified at

permit. Pages 1 and 2 should be filed within 7. Department of Heelth and Menlel Hyglene. Important: if item 27 is marked other than "na any injury or other traumatic event, the Madia once.

death with the Marylend

filed within 72 hours after

Saltimore, Maryland 21215-0020

Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury thet initieted events resulting in deeth) Last

(Check only

29b. Signeture and titla of certifier

Physician/Medical Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. ALZHEIMER'S DISEASE à 24b. Were eutopsy findings evailable prior to completion of cause of deeth? Completed 24e. Wes en autopsy 1 Yes 2 No 1 □ Yes 2 □ No 25. Wes case referred to medical exeminer? Be 28. Piece of Deeth (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Home 5 M Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e, Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Certification: 28c. injury at Work? 28d. Describe how Injury occurred 1 Netural 5 Pending investigetion 1 ☐ Yes 2 ☐ No 2 ☐ Accident 8 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Pl within 24 hours efter death. To the Funeral Director: After th completaly filled in by the funera Medical

Registrar

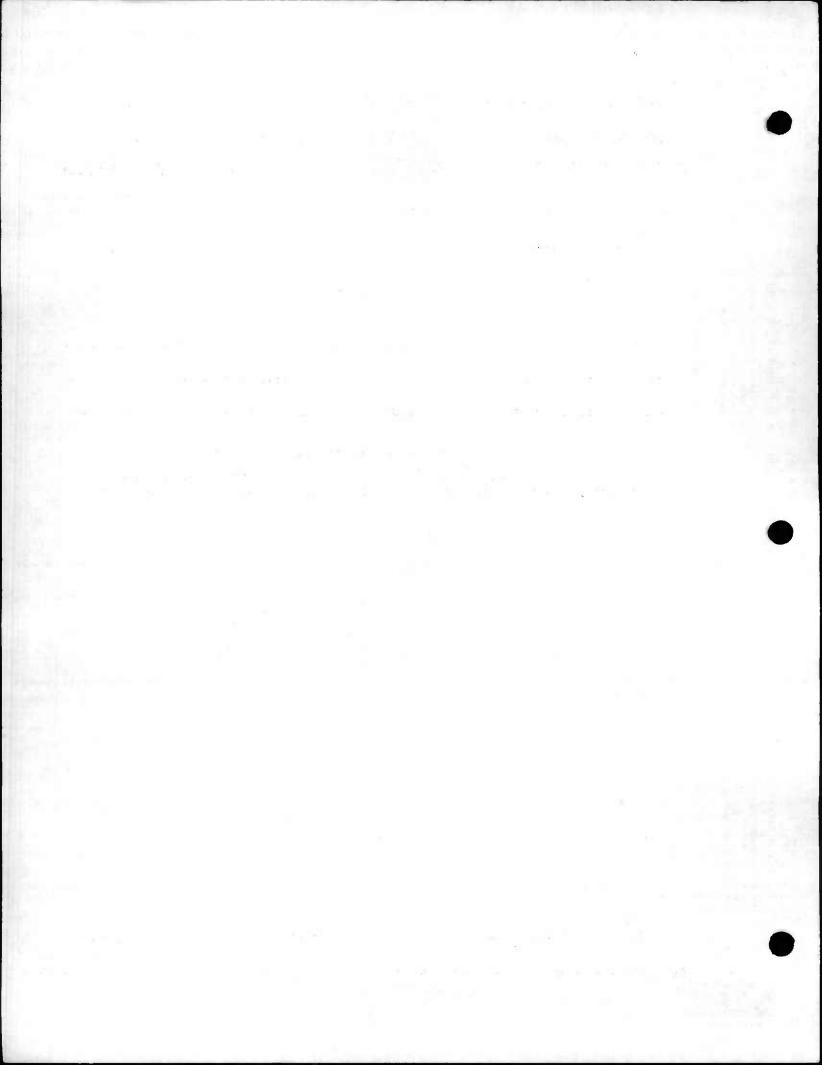
15 Certifying Physician: To the best of my knowledge, deeth occurred et tha time, dete and piece, end due to the ceuse(s) and menner as steted.

2 Medical Examiner: On the bests of examinetion and/or investigation, in my opinion, deeth occurred et the time, dete end piece, end due to the cause(s) end menner steted. 29c. License number 29d. Deta signed (Month, Dey, Year) D32186 7-7-2000

30. Neme and eddrass of person who completed causa of deeth (Item 23a) (Type, Print)

Courad hay MD

CONRAD MAY MD, BALTIMORE VAMC, 10 N GREENE ST., BALTIMORE MD 21201 31. Dete filed (Month, Pay Year) 2 2000 32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** ICHAE IAMIS 1:45pm 2000 July /Medical 4a Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALtimore City Hopkins 7. Age (In yrs. last birthday) Ohns If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Days 32 Yrs. AFRICA Director 949 11 Usuet Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show N IALYSOU 1 Ves 2 No Director GREECE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 KRITIS 85100 IRAKLIOU Нете 23а GREECE Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 12 No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or item any injury or other traumatic avant, the Medical Examinat 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1□ Yes 2₺ No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be KONSTANTINOS 12 ORTZI 19a. Informent's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PELAGIA LIAMIS Rhodes, Greece 85100 15 IRAKLION KRITIS Street 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ■ Buriel 2 □ Cremetion 3 □ Removel from State TAXIARCHIS, NECROTAFION 7-19-2000 Rhodes Greece 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Fecility Toseph N. ZANNINO JR. FUNCRAL Joseph N Ka South Street BAHO. HD 21224 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, only one cause on each line. 23a. Pilm. Enter the dis shock, or heart land Approximate tntervat Between Onset end Deeth **Physician** Immediate Ceus disease or condition resulting in death Liver Failue /Medical (Fine DAYS Examiner Due to (or as a consequence of): METASTATIC EndocRINE Tymor Physician/Medical Examiner burial-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence of): attending physician for use as the buris Box 68760 Due to (or es e consequence of) USB 88 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 XNo 3 Probably 4 Unknown signed bed bed Records, þ 24b. Were eutopsy findings available prior to completion of cause of death? ate has been si page 2 should Completed 24a. Was an eutopsy performed? 1 Yes 2 No this certificate Division of Vital To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) exeminer? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 12 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be detarmined 281. Location (Street end Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated. 2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner stated. 29a. Certifier

State Registrar

N

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

RICHARD

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32. Registrar's Signatur

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

N. WOLFE ST.

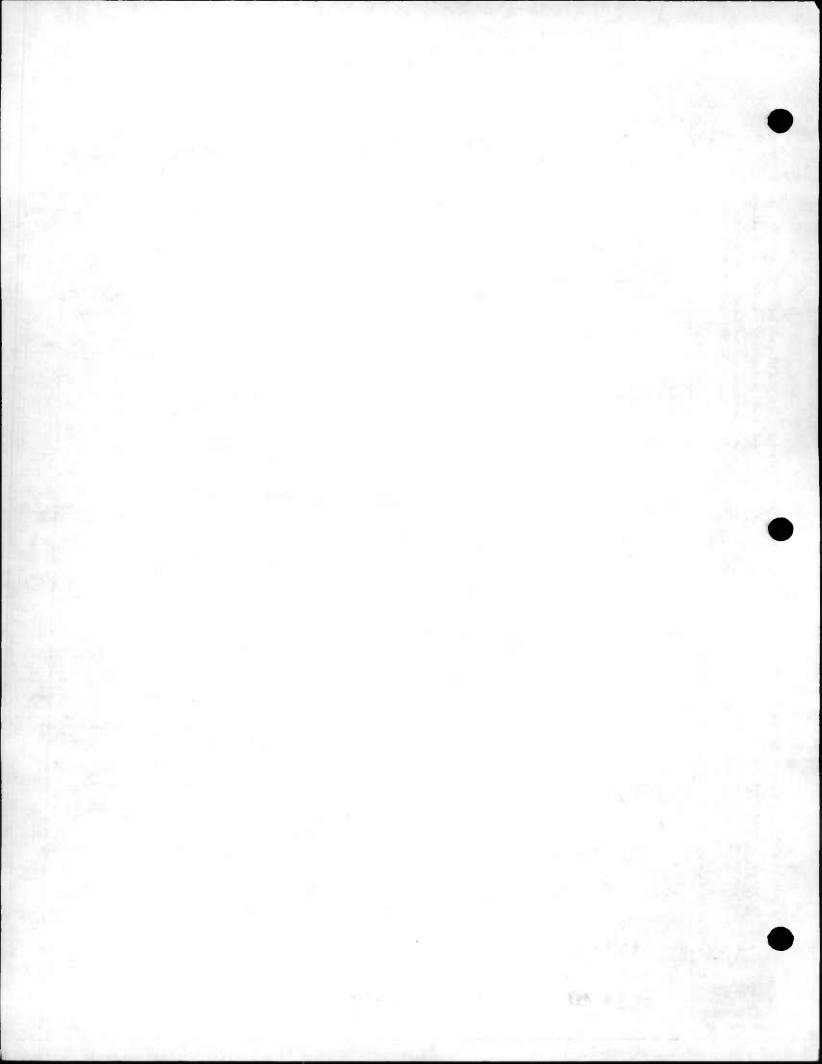
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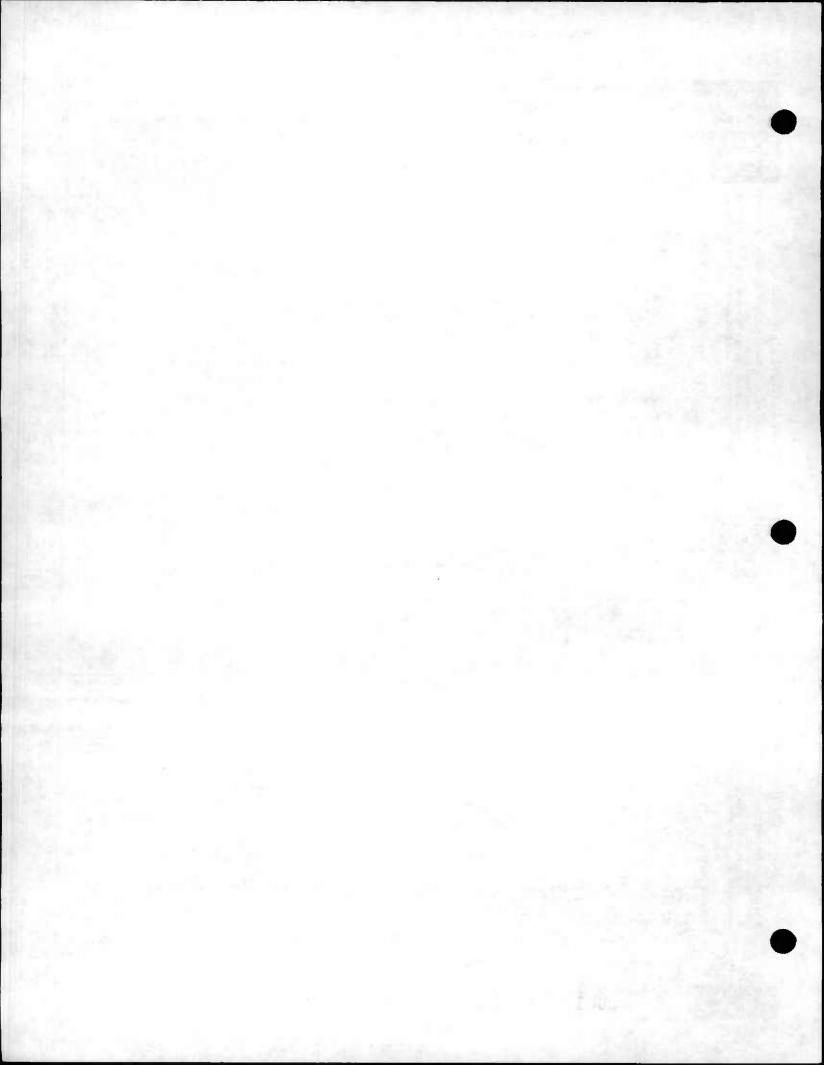


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State of Maryland / Department of Health and Mental Hygiene 22065 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Dey Physician E. GOLDYE LEVIN JULY 2000 6AM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5714 CARROLL DALE ROAD SYKESVILLE CARROLL If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 10 M 20 F 212-01-6523 89 MD. Director Usual Residence of Decedent with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MOU Hygiene. ither than "natural", or itema 23a or 28a-f ahovent, the Medical Examiner must be notified at 1 Yes 2 No Director MD CARROLL SYKESVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5714 CARROLL DALE ROAD 21784 USA Funeral filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexican, Puerto Rican, etc.) Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Mental Status 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ➡ No Specify. SpecifyWHITE þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER OWN HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Nem 27 is marked oth any lighty or other traumatic event Pates. Be 0 HARRY TOKAR **VERA** SHANE 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) SUSAN C. GOLDSTEIN/DAUGHTER 5714 CARROLL DALE ROAD SYKESVILLE, MD. 21784 20b. Place of Disposition (Name of cametery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State B'NAI ISRAEL CONGREGATION7/10/00 4 □ Donetion 5 □ Other (Specify) BALTIMORE, MD. 22. Name and Address of Fecility 21. Signature of Funeral Service Licensee SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 0 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervei Between Onset and Death **Physician** /Medical fmmediate Cause (Final disease or condition resulting in death) 3 months cuncer Lung Examiner Due to (or es e consequenca of): Examine physician and s the buriai-transit The law requires that the death certificate be assecuted Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as e consequence of): USB P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No Records, þ 24a. Was an autopsy partormed? 24b. Were autopsy findings available prior to completion of cause of death? Completed has page 1 Yes 2 No 1 Yes 2 No of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural To the Hospital or Attending Division 5 Pending investigation 1 Yes 2 No death. Director: / 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) within 24 hours after To the Funeral Direc completely filled in by after 4 T Homicide Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, end due to the cause(s) and manner es stated.

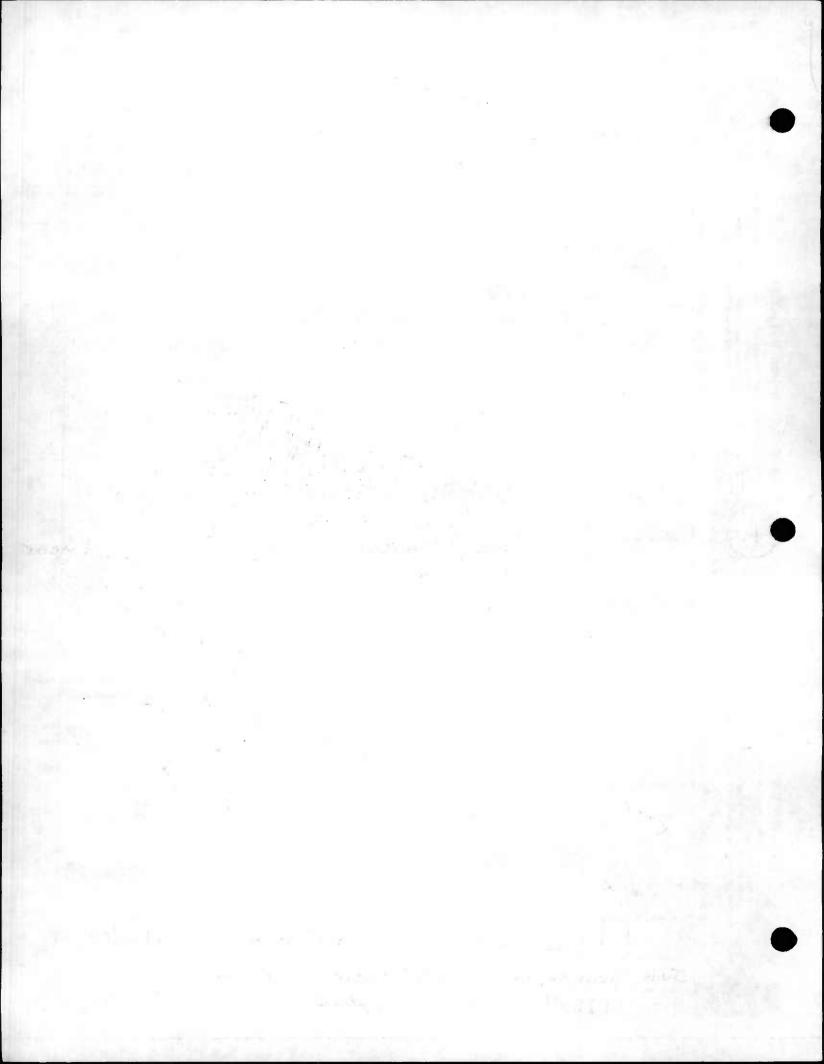
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number G- an MD D34406 July 10, 2000 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Allam Eldersburg, Richmond P. 1645 Libert Rd. MD 21784 32. Registrer's Signature 31. Date filed /Month. State Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

	Amended	Item#3 perPhyG785 7/1	.2/2000 EW	•	epartment of H Certificate of I			leg. No.	0 22066
	Physician /Medical	Decedent's Name (First, Middle, I	,	Anna Lit	z		2. Date of Dea Month June	Day	3. Time of Death 5:00 PM
	Examiner	4a Facility Name (If not institution, g 308 Orchard A			4	Baltimor		4c. County o	f Death Arundel
	Funeral Director	213 18 7675	Sex 7. Age 1 M 2 X F	(In yrs. last birthe	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day April 9	Year)	Birthplace (State or Foreign Country) Maryland
	with the Maryland a or 28a-1 show Lbe, notified at	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town o					10d. Inside City Limits
	or 28a-f show be notified at Director	Maryland Anne A	rundel	Baltim	Ore 10f. Zip Code			l0g. Citizen of Wi	1 ☐ Yes 2 🔀 No
	23a or unt ba.	308 Orchard Ave	nue		2122	5		U.S.	
020	hours after death vorsil, or thems 23s	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Ves 2 No If Yes, Give Year or Dates:	ver in U,S.	13. Was Decedent of Hill Yes, specify Cube 1 ☐ Yes 2 ☒ No	ispanic Origin? (Spe in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race	- American Indian, White, etc. White
21215-0020	다 들음 중	15. Decedent's (Specify only highest g	Education rade completed)	((ecedent's Usual Occupi Give kind of work done of fe. DO NOT use retired	during most of worki	ing	16b. Kind of Bus	
212	ed within ygiene. ver than rt. the Me	Elementary/Secondary (0-12) 12th	College (1-4or 5-	•)	Secretary			St. John	n School
pu	B state	17. Father's Name (First, Middle, La.	st)			18. Mother's Name		received to the con-	
Maryland	To To		Conrad Grae				ggie Du		
Ma	trans trans	19a. Informant's Name/Relationship Geraldine Moone			Mailing Address (Street A				tate, Zip Code) rland 21225
re,	s t and t Health Nem 27 other tr	20a. Method of Disposition	y / Daugi	20b. Place of D	isposition (Name of				ity or Town, State
Baltimore	Pages natrol mt: # lb	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			ciematory or other place idde Memor		6/29/00	Baltimo	re, Maryland
	Physician Modical Examiner	23a. Part1. Enter the disease or co shock, or heart failure. List and Immediate Cause (Finel disease or condition resulting in death)	Spanishing that caused to be cause on each line	0	ncer	ie Highwa	y Balt:	imore, M	d. 21225 Approximate Intervel Between Onset and Death
Box 68760,	let the death certificate be executed d by the ettending physicien and steeched for use as the buriel-transit. Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	bue to (or as a con					
	deeth ed for u	Part II. Other significant conditions	contributing to death but	not resulting in th	ne underlying cause give	en in Part I.	23b. Did to	obacco usa cont	ributa to the cause of death?
s, P.O.	w requires that the death cert been signed by the ettending should be deteched for use leted by Physician/M						1,000	as 2 No	3 Probably 4 Unknown
of Vital Records,	= 0 N D				-110		24a. Was a perior	n eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?
<u>~</u>	Date ha						1 🗆 Y	es 2 No	1 Yes 2 No
<u> </u>	ysicien: The lis certificate I director, pag	25. Was case referred to medical examiner?	Hospital:		Other	26. Place of Deeth	1.		
Division of	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director, Medical Certification: To Be (1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending investigate 2 Accident 6 Could not	28a. Date of Injury (Month, Day	28b. Tirr	ite of 28c. Injury	4 LI Nursing Hor		ence 6 Other	
DİVİ	Page 1	4 Homicide determine		y - At home, farm (Specity)	, street, factory, office	1	28f. Location (S City or Tow		r or Rural Route Number,
	To the Hospital within 24 hours of To the Funeral I completely filled	29a. Cortifier Cortifying P (Check only 2 Medical Exe	hysician: To the best of miner: On the basis of e and manner state	examination and/o	eath occurred at the time or investigation, in my op-	ne, date and place, a pinion, death occurre	and due to the c ed at the time, d	ause(s) and man ate end place, ar	ner es stated. nd due to the cause(s)
	To the within 2 To the comple	29b. Signature and title of certifier			29c. License		2		(Month, Day, Year)
		1/1	MD			3462	HIE	6/2	8 00
		Jude Munese		ath (Item 23a) (Ty 7845	pe, Print) OAHWO	od Ro	Ad.		
	State Registrar	31. Date filed (Month, Day, Year)	20 Decisions	's Signature	Spark.	1			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22067 AMEND ITEM: \$26 PER PHY G785 7-12-00 WR. Certificate of Death 3. Time of Death 15:05 1. Decedent's Name (First, Middle, Last) 2. Date of Death Yee Month **Physician** Floyd Majette July 2000 09 /Medical 4b. City. Town, or Location of Deeth 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner 1507 Homestead Street Baltimore NA If Under 24 Hrs. If Under 1 Year 5. Social Security Number 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) **Funeral** Days 1₽M 2□F Months 240-54-1228 64 Vrs Director 02-27-36 NC Usual Residence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits must be notified at MD 1□Yes 2□No NA Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1507 Homestead Street 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. is 1 and 2 should be filed within 72 hours after of Mealth and Mental Hygiene. Item 27 is marked other than "naturs!, or item other traumatic event, in, Medical Erampin other. Never Married 2 ☐ Married 1 XYes 2 ☐ No If Yes, Give Year or Dates: 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: ò 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Home improvement 12th Grade self-employed altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Floyd J. Pages 1 end 2 should ဥ Majette, Sr. Viola Harrison 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Reletionship (Type, Print) Sheryl D. Corry 1507 Homestead Street Baltimore, Maryland 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date Department of Himportant: If its any Injury or ot otice. MD. 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removal from State Garrison Forest VA Cem.07-14-2000 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Baltimore, Maryland 21202 21. Signeture of Funeral Service Licenses WM.C.March FH 1101 E.North Avenue Approximate
Interval Between
Onset end Death
VEARS (1990) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest shock, or heart failure. List only one cause on each line. **Physician** /Medical CARDIAC FRILLIRE | MI Immediate Cause (Final MINISTES disease or condition resulting in death) Examiner Due to (or as a consequence of): Examiner ALTHEROXLEROTIC CARDIOVASCULAR DISEASE 46483 Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. DIABRIES MELLITUS YEART TYPE 2 Physician/Medical Due to (or es a consequence of) the as MORBID OBESITY YEARS Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yss 2 No 3 Probably 4 Unknown LIPIDEMIA Records. by The lew requires ADENOCARCINOMA RECTUM TONIMO 24b. Were eutopsy findings eveilable prior to completion of ceuse of death? 24a. Was an autopsy parlomed? Completed 1 Yes 22 No OSTEOARTHRITIS 1 ☐ Yes 2 ☑ No of Vital 25. Was case referred to medical examiner?
1 Yes 2 No Be 26. Place of Death (Check only one) To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Menper of Death Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred After 5 Pending investigation 1 Natural Division or Attending s after death. 1 Tes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide filled in 24 hours Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

| Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the ceuse(s) and manner stated. edical 29a. Certifier within 24 hor To the Fune completely fi (Check only 29b. Signature and title of outsits 29c. License number 29d. Date signed (Month, Dey, Year) D16333 mes & molino, m 07-10-2000

State Registrar

DHMH 16 Rsv 6/95

31. Date filed (Month, Day, Year)

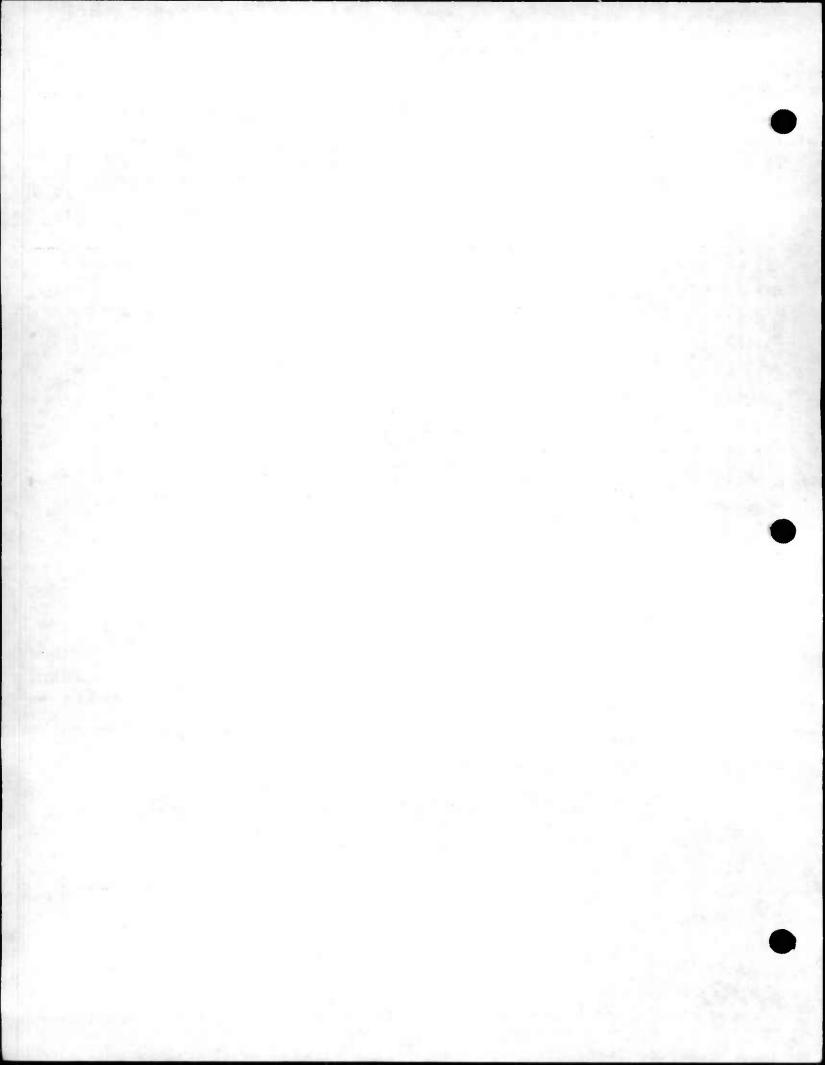
2000 JUL 12

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrer's Signeture

ERNE GTO MOTERNO,40. 3450 ELLICOTI CT. DR. SOME 105 - ELLICOTI CITY-MO 21043

ORIGINAL

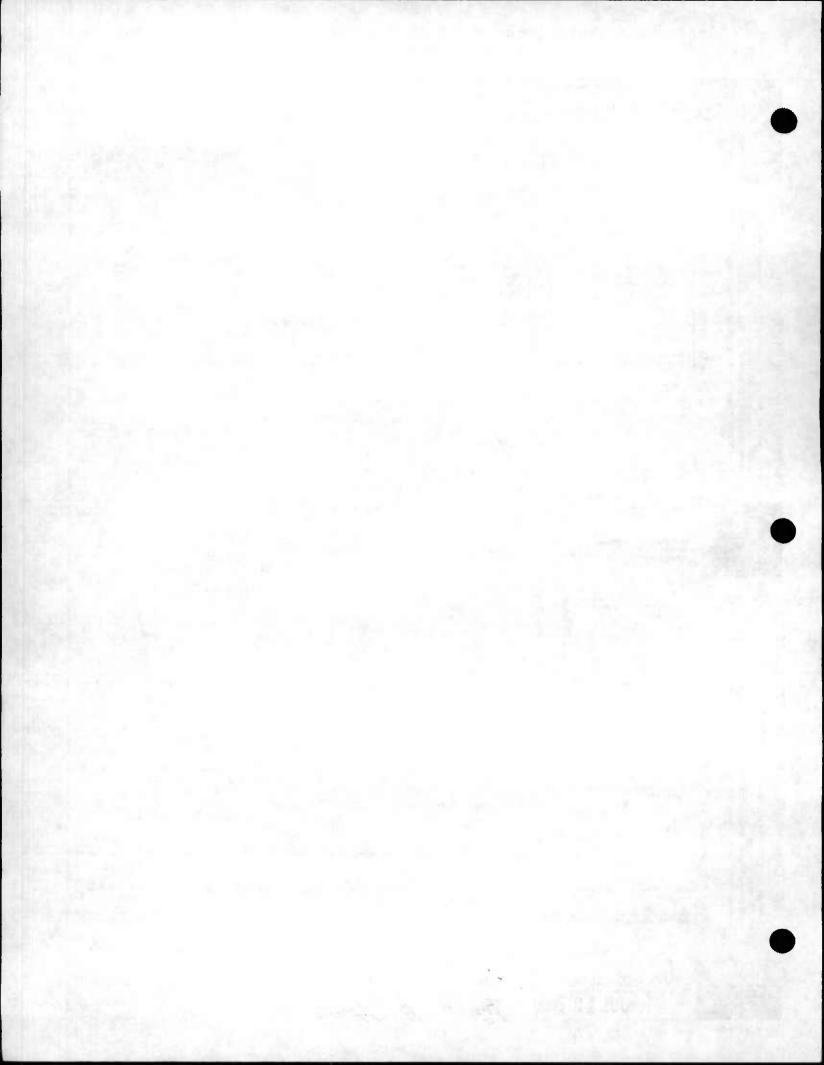


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State of Maryland / Department of Health and Mental Hygiene

	1. Decedent's Na	me (First Mid	idle Last							2. Date	Reç of Death			3. Time of
cian	Herbert									Mont July	1	Day 2000	Year	19:01
dical iner	4a Facility Name				mber)				4b. City, Town	, or Location of		4c. County	of Death	19:01
iller	Howard					1			Colu	mbia		Howa		
ı T	5. Social Security		6. Sex		7. Age (In y	rs. last birthde	Months	er 1 Yaar s Days	If Undar 24	Hrs. 8. Date	of Birth			place (State o
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State of Maryland / Department of Health and Mental Hygiene 22069 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Physician GENOA MORSE JULY 09, 2000 3:52pm/Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner SINAI HOSPITAL OF BALTIMORE BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 03-08-20 Birthplace (State or Foreign Country) VIRGINIA **Funeral** Months 1□M 20 F Days Hours 579-24-0147 80 Director troa **Usual Residence of Decedent** 10a, State 10c. City, Town or Location 10d. Inside City Limits ahow 1X Yes 2 □ No Director MD N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? than "natural", or itema 23a or the Medical Examiner must be a 4617 TALMAN ROAD 21208 U.S.A. Funeral filed within 72 hours efter deeth Hygiane. 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status S 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: BLACK Specify. Š 3 Widowed 4 □ Divorced NOW Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) TELLER COMMUNICATIONS 8 Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) 8 Pages 1 and 2 should be fli tment of Health end Mental H tent: If Itam 27 le marked out 2 ANDREW MORSE SALLIE HUDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) permit. Pages 1 and 2: Department of Health el Important: If Itam 27 le eny Injury or other trau 4617 TALMAN RD, BALTIMORE, MD GWEN E. MORSE 21208 Baitimore, 20a. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 □ Burial 2 □ Cremation 3 □ Removal from State WOODLAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 7-14-00 WOODLAWN, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility HOWELL FUNERAL 4600 LIBERTY HGHTS AVE, BALTO. MD 21207 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Aspiration Examiner Due to (or as a consequence of) Cerebral Vascu the buriel-transit The law requires that the death certificete be executed Exam Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, attending physician for use as the burie Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dld tobacco use contribute to the cause of death? page 2 should be detached 3 Probably 4 Unknown 2 X No 1 Yes Be Completed by 24b. Were eutopsy tindings available prior to completion of cause of death? 24a. Wes en eutopsy performed? cartificate has 2 No 1 Yes 1 ☐ Yes 2 ☐ No of Vital after death. Director: After this cartification by the funeral director. Attending Physicien: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of D 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) filled in by 4 ☐ Homicide 5 To the Hospital within 24 hours a To the Funeral D completaly filled Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated. Medical Examiner: On the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner stated. And menner stated. Medical 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signafure? 29c. License number

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

2004

2000

G. Barnord

Kathryn G 31. Date filed (Month, Day, Year)

W

DHMH 16 Rev 6/95

State

Registrar

32. Registrar's Signature

of death (Item 23a) (Type, Print)

of Baltimore

ORIGINAL

Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Day reverowit **Physician** 2000 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner Baltimore Gristmil Court Apartment 8. Date of Birth NOV 2 1918 If Under 1 Year 9. Birthplace (State or Foreign NEW YORK 7. Age (In yrs. last birthday) 6. Sax **Funeral** Months Days Hours 064-07-0009 10 M AFF Director Usuat Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits , or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2√ No **Funeral Directon** BALTIMORE BALTIMORE 10a: Street and Number 10f. Zin Code 10g. Citizen of What Country? 21208 USA 1 GRISTMILL COURT APT. 407 permit. Peges 1 and 2 should be filed within 72 hours efter dee Department of Heelih and Mental Hygiene. important: If them 27 is marked other than 3 any Injury or other trainment. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, apecify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2(XNo If Yes, Give 1 Nevar Married 2 Married 1 ☐ Yes 2 ☐ No Specify. þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) Cottoge (1-4or 5+) RETAIL MERCHANT 18. Mother's Name (First, Middle, Meiden Surname) 17. Father's Name (First, Middla, Last) Be BIER CHARLES SEROTA HANNAH 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 46 STIRRUP COURT BALTIMORE, MD. 21208 PEGGY MEYEROWITZ/DAUGHTER 20b. Place of Disposition (Name of cematery, crematory or other place) 20a. Method of Dispositio 20c. Location - City or Town, State 1 X Buriat 2 ☐ Cemation 3 ☐ Ramoval from 4 ☐ Donation 5 ☐ Other (Specify) 7/10/00 REISTERSTOWN, MD. BALTIMORE HEBREW 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between Onset and Deeth 23a. Part1. Enter the shock, or heart t **Physician** /Medical Immediate Cause (Finel emen disease or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Box 68760, Physician/Medical Due to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. signed by t 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes an autopsy performed? 24b. Were autopsy findings available prior to Completed completion of cause of death? hes 1 Yas 2 No 1 ☐ Yes 2 No or Attanding Physician: 25. Was case referred to medical examinar? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatlent 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No After this funerel 28d. Describe how injury occurred 27. Menner of Death Certification: 28a. Dete of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 1 Neturet 2 Accident 5 Pending investigation s after deeth. I Director: Af 1 Yes 2 No 6 Could not be determined 3 ☐ Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Ptace of tnjury - At home, farm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide filled in within 24 hours a To the Funeral C completely filled Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one)

8.4

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State Registrar

31. Date filed (Month, Day, Year) 2000 JUL

Srodon

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier

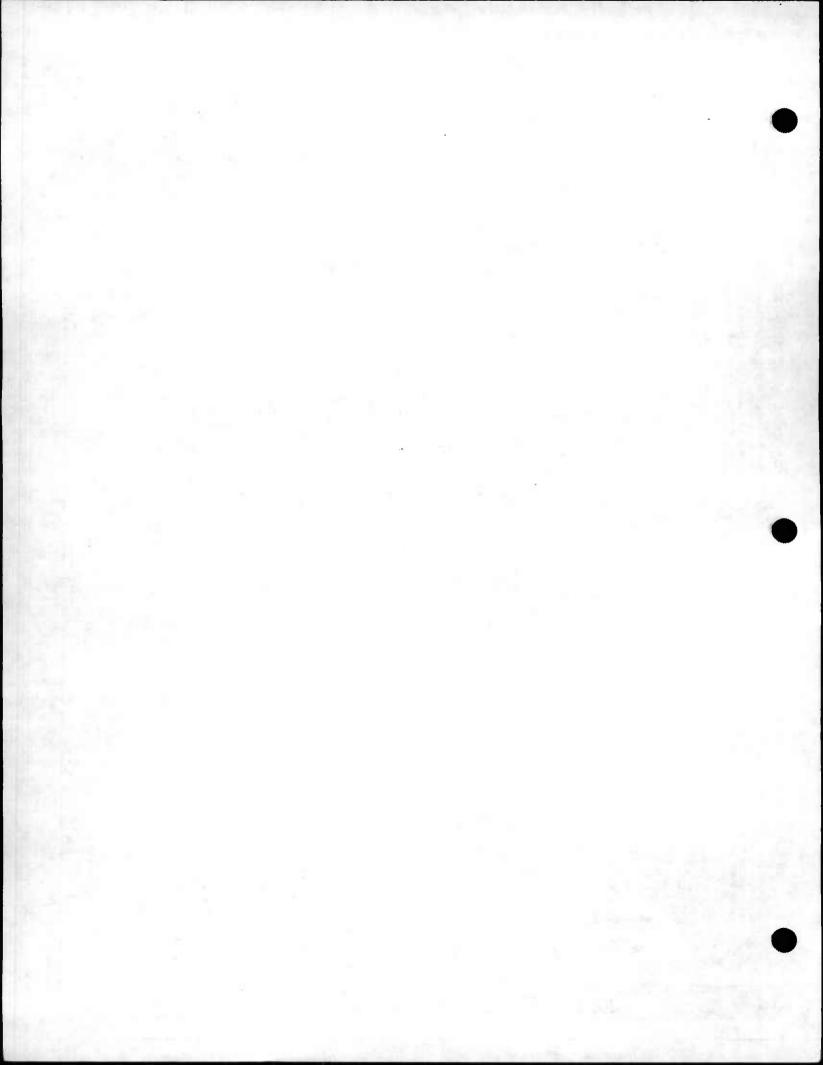
Monica

MD 600 32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

Street Baltomice, Maryland 2128)

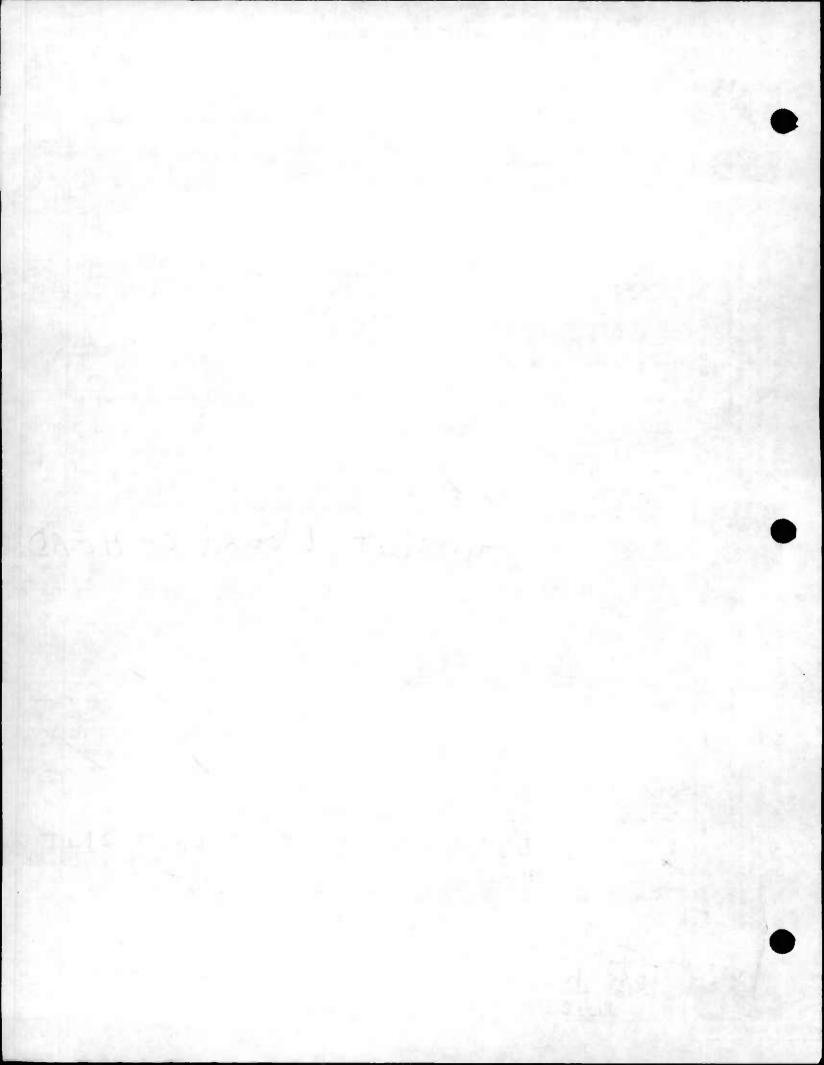


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State of Maryland / Department of Health and Mental Hygiene

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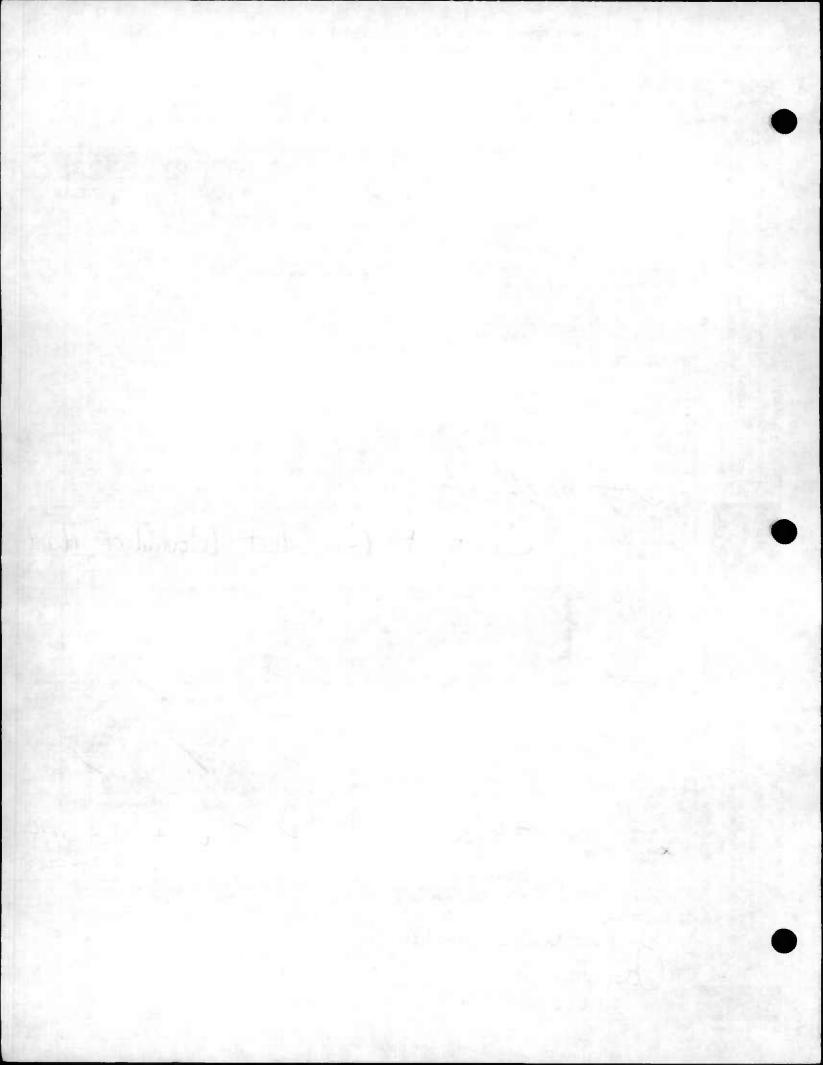
-3759-510	State	of Maryland / De	partment of I			ene 00	22071		
THE R. P. LEWIS CO., LANSING	Decedent's Name (First, Middle, Last)				2. Date of Deeth		3. Time of Death		
Physician /Medical	Albert William Meyers			H. Too	Month JULY	8, 2000	1947 PM		
Examiner	4a Facility Name (If not institution, give street end of 33 N. KRESSON STREET	number)		4b. City, Town, or Lo BALTIMORE		4c. County of Death			
Funeral Director	5. Social Security Number 6. Sex 1⊠ M 2□ F	7. Age (In yrs. last birthda 77 Yrs.	Months Days		8. Date of Birth (Month, Pay, Y 12/25/19	(ear) 9. Birth Cou Ma:	place (Stete or Foreign ntry) cyland		
р ,	Usual Residence of Decedent 10a. Stete 10b. County	10c. City, Town or	t anation				lod balds Ob. Usin		
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Marylca d 2 should th end Mer 7 is marks traumatic	19a. Informant's Name/Relationship (Type, Print) Ronald Meyers/Son					City or Town, Stete, Zij			
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Divisio To the Hospital or Atlandi within 24 hours after death. To the Funeral Director: A completely filled in by the fi	(Check only 20 Medical Examiner: On the								
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F ≯ F &	1 CP 1stan	en MD	OCME		J	ULY 9, 20	000		
	30. Name and address of person who completed co	suse of death (ftern 23a) (Turn	pe, Print)						
VY	Joseph Pest			Baltimor	e, Maryla	and 21201			
State	31. Date filed (Month, Day, Year) 32	. Registrar's Signature	1 1		_				
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State of Maryland / Department of Health and Mental Hygiene 00 22072

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Jouge 6605 /Medical 4a Facility Name (If per partition, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Monto anery silver? press 1014 5. Social Security Number 150-34-5712 If Under 1 Year If Under 24 Hrs. B. Date of Birth (Month, Day, 06 - 04 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 F Days Yrs Director **Usual Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mantal Hygiane. Important: If item 27 is marked other than "natural", or itema 23a or 28a-f ahow with injury or other traumatic event, the Medical Exeminal must be notified at DDG. Springs Montgomen Silver 1 ☐ Yes 2 ☑ NO Director Marylan 10e. Street and Number 10g. Citizen of What Country? 2122 Randol Road ph 20902 Completed by Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates: 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify Specify: 3 Widowed 4 □ Divorced 5/ack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) D. C. - Education - Sister Music, Math + Science Supervising 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 8 Catherine Gordan Willis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Walter Green Randolph Road, Silver Springs, MD 20902 2515 Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/13/2000 Atlantie City Greenwood 4 ☐ Donation 5 ☐ Other (Specify) emetery 21. Signature of Fundral Service Licentified 22. Name and Address of F Havi P. C. 709 Tess Funeral Service, P. A. Tesster Street, 21201-1924 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner To the Mospital or Attanding Physician: The law requires that the death certificate be associated within 24 brouts after death.

To the Funeral Director: After this certificate has been signed by the attending physician end completely filled in by the funeral director, page 2 should be detached for use as the burial-transit completely filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of). Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown à 24b. Were autopsy findings available prior to completion of cause of deeth? Be Completed 24a. Wes en eutopsy performed? money ! 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ 116 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inputient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 DER/Outpatient 3 DOA Medical Certification: To 1 Yes 2 No 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how Injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 16 Rev 6/95

State

Registrar

MO

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2000

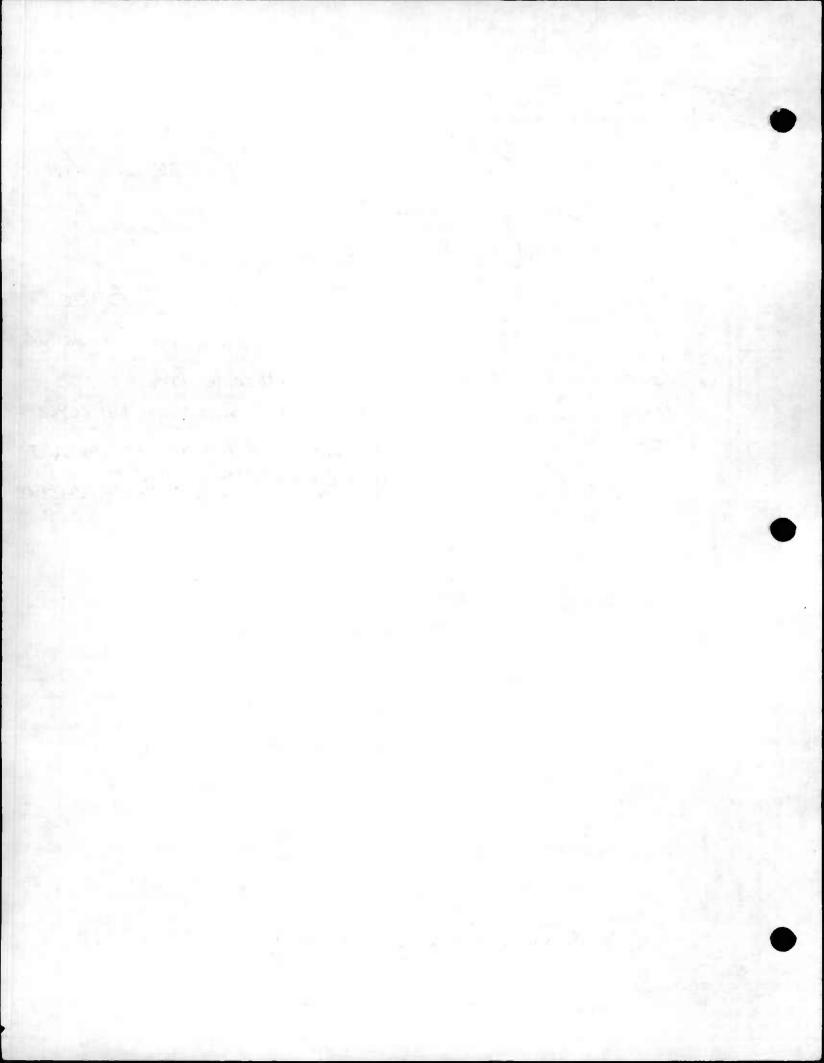
31. Date filed (Month, Day, Year)

JUL 12

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Item 25 per ME, dhb 7/12/00 G785 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month **Physician** Harry Joseph Patton July 2000 6, 5:15 a.m. /Medical 4e. Fecility Neme (If not institution, give street end number) 4c. County of Deeth 4b. City, Town, or Location of Deeth Examiner Broadmead Cockeysville Baltimore If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Birthplece (Stete or Foreign Country) Months Deys 10 M 2 □ F **Director** 272-10-2906 85 March 7, 1915 Ohio Usual Residence of Decedent Maryland 10b. County 10c. City. Town or Location or 28a-1 show 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 ☐ Yes 2X No Baltimore Cockeysville the 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? Herns 23a 13801 York Road 21030 Funeral USA 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien. Permit. Peges 1 and 2 should be filed within 72 hours effect be pearment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural" and appropriate your other traumetic available. Bleck, White, etc. 1 ☐ Yes 2 🗓 No If Yes, Give Year or Detes: 1 Never Married 2 Married 1□ Yes X□ No White ģ Specify. 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) photographer museum 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Be 2 Patton Dennis Lesta Correne Davis 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Broadmead 13801 York Road Cockesyville, MD 20e. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other place) Dete 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4D Donetion 5 Other (Specify) vice Licensee 21. Signature of Fundral Service Ronal Id 22. Neme end Address of Fecility
State Anatomy Board Director 655 W. Baltimore Street hole naus Baltimore, MD 21201 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximete Intervel Between Onset end Death Physicien. Immediate Ceuse (Finel diseese or condition resulting in death) / vie dic al Examiner Physician/Medical Examiner The law requires that the death certificete be executed Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initieted events resulting in deeth) Lest attending physician end for use as the bunal-trar Due to (or es e consequence of). Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of): ed by the a detached f Pert II. Other significent conditions contributing to deeth but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b þ Completed 24b. Were eutopsy findings evelleble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? ate hes t 1 🗆 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Be 25. Wes cese referred to medical exeminer? 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 27. Menner of Death 28e. Date of Injury (Month, Dey Year) 28c. Injury et Work? 28b. Time of 28d. Describe how injury occurred 5 Pending Investigation 1 Neturel 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide

To the Hospital or Attending Physician: s efter death.
I Director: After this of in by the funeral d within 24 hours eft To the Funeral DI completely filled Ir

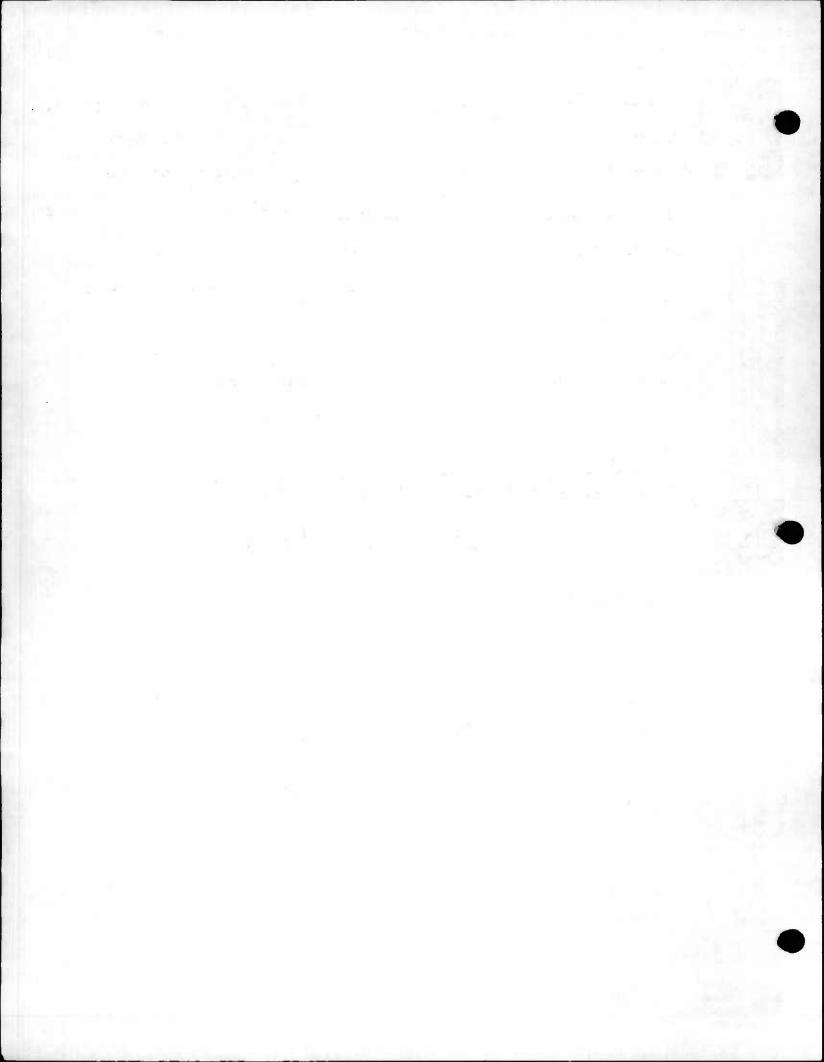
29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of exeminetion end/or investigetion, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signature, end title of certifier 29c. License number 29d. Dete signed (Month, Dey, Year)

deeth (Item 23e) (Type, Print)

32. Registrer's Signeture

YORK RD.,

State Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Daath **Physician** ZOLMAN RIMSON /Medical 4e. Facility Nama (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner BALTIMORE HOSPITAL OF BALTIMORE If Under 1 Year II Under 24 Hrs. 8. Date of Birth Months Days Hours Min. JAN 1920 7. Aga (In yrs. last birthday) **Funeral** ¥ M 2 F 80 Director 213-12-4019 Usuel Rasidanca of Decedent RIMSON death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location permit. Peges 1 end 2 should be filed within 72 hours effer death with the Marylei Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or items 23s or 28e4 show any injury or other traumatic event, in Medical Examiner must be not lied and opice. or 28a-f show **Funeral Director** MD BALTIMORE BALTIMORE 10f. Zip Coda 21208 10a, Street and Number 10 MONTAIGNE COURT APT. 2-B 12. Was Decedant Evar in U,S. Armed Forces? Was Dacedant of Hispenic Origin? (Spacify Yas or No-If Yas, specify Cuben, Maxican, Puerto Rican, atc.) 35 t⊟Yas 2□NoWW II K¥es, Giva Yaar or Dates: 1 Nevar Married 2 Merriad Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: þ 3 Widowed 4 □ Divorced KNOWN Completed 16a. Decedant's Usuel Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) **MECHANIC** 17. Fathar's Name (First, Middla, Last) 18. Mothar's Name (First, Middle, Maidan Surnama) Be **ABRAHAM** RIMSON BELLA 2 19a. Informent's Name/Raletionship (Type, Print) LILLIAN STICHMAN/SISTER-IN-LAW 20b. Placa of Disposition (Nema of camatary, cramatory or other place) 20a. Method of Disposition MXBurlai 2 Cramation 3 Removal from Stata ADATH YESHURUN 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Efinarai Service Licenses 22. Nama end Addrass of Facility Physician

8900 REISTERSTOWN ROAD PIKESVILLE, MD. 21208 23e. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intervel Between Onset and Death CARDIOGENIC Immediata Causa (Final diseasa or condition resulting in death) Dua to (or es e consequance of): HOUTE mI Exami Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as e consaquence of): Completed by Physician/Medical Due to (or as a consequence of) Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 1 Yes 2 No 3 Probably 4 Onknown ACUTE RESPIR. DISTRESS SYNDROME 24b. Wara autopsy findings available prior to completion of cause of death? RENAL FAILURE 24e. Was an autopsy 1 ☐ Yes 2 No 1 Yes 2 No

1 inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

28e. Plece of Injury - At home, ferm, streat, factory, office building, atc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

deteched Be 10 Certification:

attending physician or Attending Physician: The law requires that the death certificate be After this certificate hes within 24 hours after deeth. To the Funeral Director: A the 3 To the Hospital

Division of Vital Records, P.O. Box 68760,

/Medical Examiner

B. M

KOLEN

5 Panding invastigation

6 Could not be datamined

25. Was casa referred to medical axaminar?

29b. Signatura and titla of certifles

1 Yas 2 No

27. Mannar of Death

1 Natural 2 Accident

3 ☐ Suicida

29a. Certifier

4 Homicide

(Check only

29c. Licansa number

28c. Injury et Work?

1 ☐ Yas 2 ☐ No

29d. Deta signed (Month, Day, Year) 2000

30. Nama and addrass of parson who complated cause of daeth (item 23a) (Type, Print) .

Hospital:

28a. Data of Injury (Month, Day Year)

HOSPITAL OF BALTIMORE SINAI

32. Registrar's Signature

Registrar

Medical

DHMH 16 Ray 6/95

3. Time of Death

0120

2000

4c. County of Deeth

N/A

9. Birthplece (State or Foreign

10d, Insida City Limits

1 ☐ Yas 2 No 10g. Citizan of What Country?

USA

 Reca - American Indian, Black, Whita, atc. Specify: WHITE

16b. Kind of Business/Industry

AUTOMOBILE

LUNTZ

19b. Malling Address (Street and Number or Rurel Route Number, City or Town, Stete, Zip Code)

10 MONTAIGNE COURT APT. 2-A BALTIMORE, MD. 21208

20c. Location - City or Town, Stata

7/10/00 BALTIMORE, MD.

SOL LEVINSON & BROS. INC.

23b. Did tobacco use contribute to the cause of death?

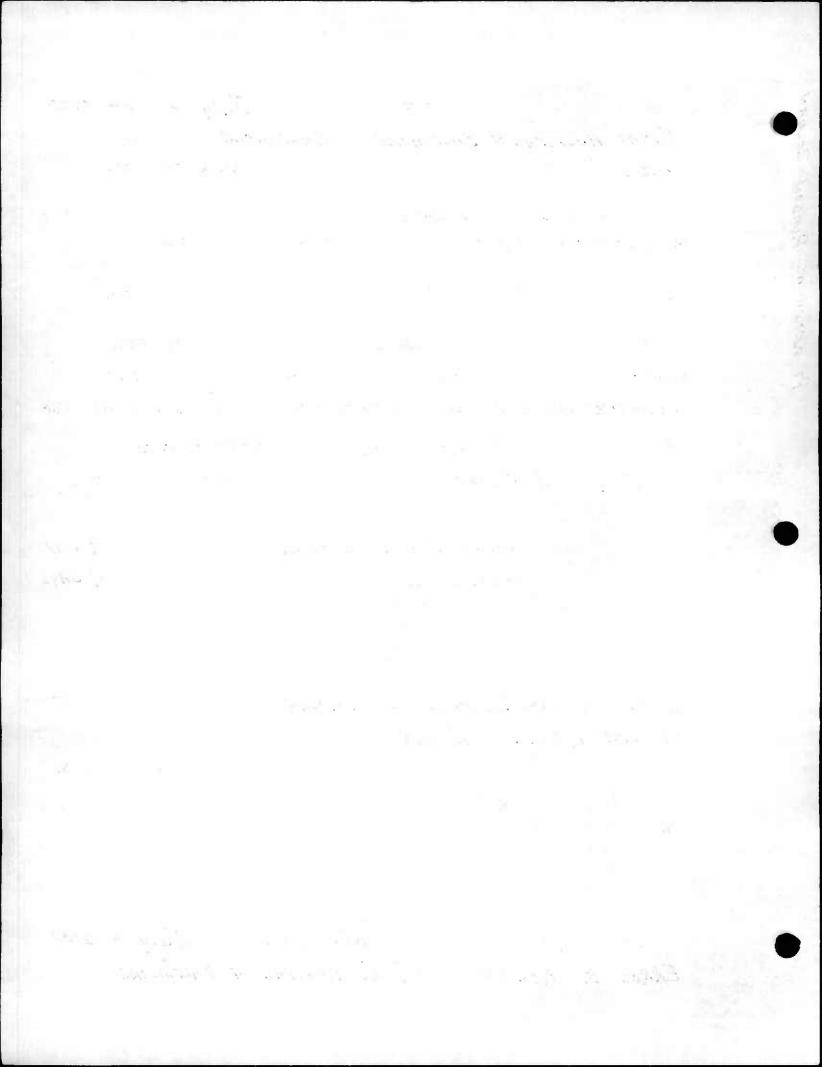
26. Piaca of Daath (Check only ona)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Dascribe how injury occurred

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

Cartifying Physician: To the best of my knowledge, deeth occurred et tha tima, dete end piece, and due to the ceuse(s) end mannar as stated.

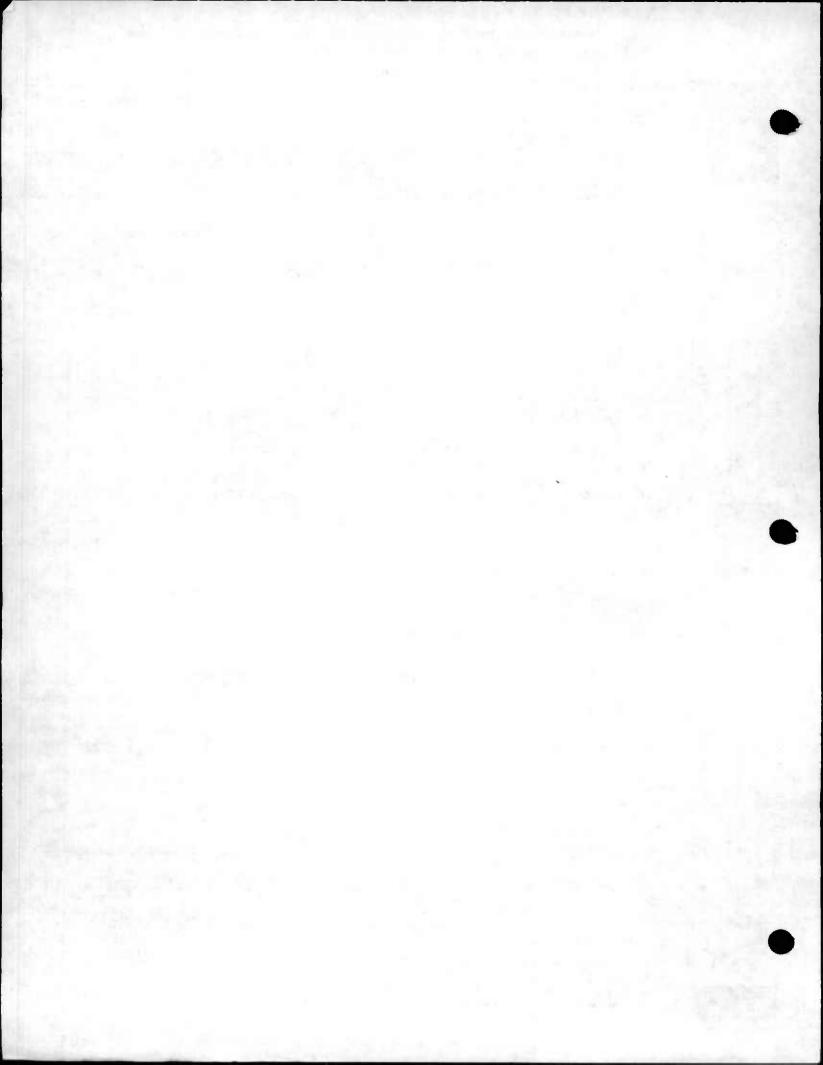
| Medical Examiner: On the basis of axamination and/or investigetion, in my opinion, deeth occurred at tha tima, deta and piaca, and due to the causa(s) end mannar stated.



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State of Maryland / Department of Health and Mental Hygiene 00 22076

					Cei	tificate	e of l	Death			Reg. No.			
ysician	Decedent's Name (First, Middle, Last)									2. Date of De Month				
cal -	ANNA			RIBER	KOF					JULY	10	2000	5:40AM	
161	4a Facility Name (If not institution, give street end number) MILFORD MANOR NURSING HOME								4b. City, Town, or Location of Death BALTIMORE BALTIMORE der 1 Year If Under 24 Hrs. 8 Date of Birth					
r	5. Social Security Number 216-36-7793		х Эм ж Эг	Age (In yrs.	last birthdey) Yrs.	If Under Months	Deys	Hours	Min.	8. Date of Bir 12/27/.	1909	9. Birth	place (Stete or Foreign in(ry) D.	
	Usual Residence of Deced			10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits	
Director												1 ☐ Yes 2 ☐ No		
at Dir	10e. Street and Number 10f. Zip Code 6634 SANZO ROAD #A 21209										10g. Citizen of What Country? USA			
by Funeral	11. Marital Status 1 Never Married 2	Married	Armed Ford 1 ☐ Yes 2 If Yes, Give	12. Was Decedent Ever in U,S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		 13. Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto I 1 ☐ Yes 2 X No Specify: 			ecify Yes or No Ricen, etc.)		lace - Amer Black, White city: WHI			
eted	15. De (Specify only			(Give	ient's Usua kind of wor	k done	during mos	st of worki	in <i>g</i>	16b. Kind of	Business/I	ndustry		
Completed	Elementary/Secondary (College (1-4or 5+)				e retired	"			CDCCE	V COO	ND IZ		
B	17. Fether's Neme (First, M ISRAEL	liddle, Last)		CASHIER			18. Mother's Neme (First, Mi			e (First, Middle				
To	19a. Informant's Name/Re			FRIED	19b. Meilir	1 (2.3)	(Street			el Route Numb		vn, Stete, Z	ip Code)	
-	SHEILA HYATT/	'DAUGH'I	TER	an r	1			E WAY	BAL	TIMORE			Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Contract Con	
	20a. Method of Disposition 1		Removal from St	ate	Place of Dispo cemetery, crer NAI JAC	netory or of	her pled		ON 7	/11/00	BALTIM			
	21. Signature of Faheral S	pojco Licegly	- Are	-		. Name an			SOL	LEVINS				
-	23a. Part Enter the diseashock, or heart feilure	ise, or combi	ications in the	sed the deel	th. Do not ent	er the mode	of dvin	ERSTO	WN R	OAD PIP	KESVILL arrest.	E, MD	Approximete Interval Between	
	shock, or heart feilure	. List only o	ne came on ee	ch line.			10						Interval Between Onset and Death	
	Immediate Cause (Final disease or condition resulting in death)		Cri		C Ac		2	ten	asi's			1 2	Years	
cal Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events										R SEE			
n/Medical														
sicia	Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I							l.	23b. Did tobacco use contributs to the cause of					
y Ph	Severe chronic obstructive pulmonary disease (related to organite use)									1)2	obably 4 Unknown			
Completed by Physician	dreese	(1	related	to	crgar	ette	- u	se)		24a. Was	s an autopsy ormed?	8	Were autopsy findings available prior to completion of ceuse of death?	
E O										10	Yes 2/N	0 1	1 ☐ Yes 2 ☐ No	
Be	25. Was case referred to n examiner?	-							e of Deat	h (Check only	one)			
2	1 ☐ Yes 2 ☑ No	1								ome 5 Residence 6 Other (Specify)				
Certification:	2 Accident	Pending nvestigation	28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Yes 2 N						28d. Describe how injury occurred No					
Sertific	3 ☐ Suicide 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6 ☐ 6	Could not be determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					281. Location (Street end Number or Rurel Route Number, City or Town, Stete)						
edical O	29e. Certifier 2 Certifier (Check only one)	rtifying Phys dical Exami	sician: To the b	is of examina	owledge, death ation and/or in	occurred a	at the tin	ne, dete ar pinion, dea	nd place, ath occurr	and due to the red at the time	cause(s) and , date end pla	manner as ce, and due	stated. to the cause(s)	
	29b. Signature and title of	ertifier	2112 1110111110					e number			29d. Date sig	ned (Monti	h, Dey, Year)	
y -	▶ DRo	gge-	_				D 3	228	44	town				
1	30. Name and address of p			of deeth (Iter		Print) Road	, /	Rand	all8	town	mo	211	33	
	31. Date flied (Months Day,	Veerle 0	000 32 Be	igrar's Sign	atura /	4								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Vasi 8.15 AM **Physician** LOUIS SORRELL 09 July ZOY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner altimore Itospita If Under 24 Hrs. If Under 1 Year Birthplace (State or Foreign Country)
 MARYLAND 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 5. Social Security Number **Funeral** Months Houra M 2DF Yrs. 216-22-3191 70 AUG.10,1929 Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. fnaide City Limits the Medical Examiner must be notified at 1 Yes 2 No N/A MD. BALTIMORE Funeral Director 288-1 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number or Itema 23a or RADECKE APT.B1 U.S.A. 5700 21206 AVE 14. Raca - American Indian Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Pages 1 and 2 should be filed within 72 hours after Yes 2 No 2 Married 21215-0020 1□ Yes 20 No Specify Specify: Completed by 4 Divorced 3 Widowed Year or Dates: BLACK 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hyglene. Elementary/Secondary (0-12) 12th College (1-4or 5+) N/A INDUSTRY STOCK WORKER BAKING Baitimore, Maryland 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be it of Health and Mental JOHN SORRELL BERTHA WOODS 19b. Meiling Addresa (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) SHEILA MAYO- DAUGHTER 5700 RADECKE AVE.BALTO.MD.21206 APT.B1 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete Date Burial 2 Cremation 3 Removal from State 4 Donetion 5 Other (Specify) Depertment of Important: If any injury or ZION CEMETERY 7/18/00 LANSDOWNE, MARYLAND MOUNT 22. Neme and Address of Fecility 21. Signature of Funeral Service Licensee LEWIS T.GWYNNFUNERAL HOME EWIS T.GWYNN 4517 PARKHEIGHTS AVE.BALTIMORE, MD. 21215 Levenu 23a. Part 1. Enter the disease, or complications that caused he death. Do not enter the mode of dying, such as cardiec or respiretory errest, shock, or heart feilure. List only one cause of each line. Approximete Intervai Between Onset end Deeth **Physician** immediete Ceuse (Final diseese or condition resulting in death) /Medical Examiner Examiner The law requires that the death certificate be assecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Did tobacco use contribute to the cause of death? 1 Yee 3 No 3 Probably 4 Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1□ Yes 2No Hospital: Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA jo 27. Manner of Dea 1 Neturel 2 Accident 28c. Injury et Work? 28d. Describe how injury occurred Division Attanding 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 Homicide 0 within 24 hours Certifying Physician: To the best of my knowledge, deeth occurred at the tima, dete end place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ated cause of death (Item 23a) (Type, Print) ax -Dirk 31. Date filed (Month, Day, Year) 32. Registrer's Signature State Registrar

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Fun Direc	eral	214-94-00/4	2 7. Ag	e (In yrs. last birthda 20 Yrs.	y) If Under 1 Yaa Months Days		8. Date of Birth Month, Day JAN . 24	N/A N/Year) 1980 M			
	tor	Usual Rasidence of Decedant 10a. Stata 10b. County MD , N/A		10c. City, Town or	Location FIMORE				10d. Inside City Limits 1 Yes 2 □ No		
ith with the Maryla 23e or 28e-f ahon	Funeral Director	10e. Street and Number 4169 FAIRVIEW	AVE.		10f. Zip Coda 2121			U.S.A	t Country?		
020 urs after deat ur, or Neme	by Funer	11. Marital Status 1 Navar Marriad 2 Married 3 Widowed 4 Divorced	12. Was Dacedent Armed Forces? 1 ☐ Yas 2 IV If Yas, Give Yaar or Datas:	Ever in U,S. 13	8. Was Decedant of If Yas, specify Cu	Hispanic Origin? (Sp ban, Maxican, Puerto o Specify:	ecify Yas or No- Rican, atc.)	200	American Indian, White, atc. BLACK		
21215-0020 within 72 hours after death with the Maryland jiene. r than "natural", or Nems 23s or 28s-1 show	Be Completed	15. Decedent's Ed (Specify only highast grad Elemantary/Secondary (0-12) 1 2 t h	ucation da completed) N/A	(Gin	. DO NOT use retir	e during most of work		16b. Kind of Businass/Industry			
Maryiand 2 d 2 should be filed th and Mental Hygis	To Be C	17. Fathar's Nema (First, Middla, Last) JAMES EZELL	SPENC	EER		18. Mother's Nam		Meiden Sumama) RLENE	JONES		
- 258	ner trauma	19a. Informant's Name/Reletionship (7 ERNESTINE JONE		OTHER 4	4169 FA	et and Number or Rui	VE.BAI	TO.MD.2	1216		
Itimore, It. Pages 1 an Itiment of Hear	ar on	20a. Mathod of Disposition 20b. Place of Disposition (Name of cematery, crematory or other place) 20b. Place of Disposition (Name of cematery, crematory or other place) DRUID RIDGE CEMETERY 7/15/00 PIKESVILLE, MD.									
Ball pamit Depart Import	any in	21. Signature of Edheral Service Licens	ENIS	TO THE LAND		rass of Facility LEV			NERAL HOME .21215-6393		
Physic /Med Exami	ical ner	23a. Part1. Entar the disease, or comp shock, or heart failure. List only of immediate Cause (Final disease or condition resulting in death)	a.	the death. Do not a	Eusto	ying, such as cardiac		rest,	Approximete Interval Between Onsat and Death		
os fou, ficate be associted g physician and as the burial-transit	£ £	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated avants resulting in death) Last	b	Dua to (or as a cons							
P.O. BOX 68 at the death certificat by the attending phy	Physician/Mec	Part II. Other significant conditions co	dntributing to death b	23b. Did tobacco use contribute to the cause of d							
Hecords, he law requires th he has been signed age 2 should be d	should be d							an autopsy 2 2 mmed? 2 □ No	24b. Ware autopsy findings available prior to completion of cause of death?		
ysician: Tysician: T	Grector director	25. Was casa ratarred to medical axaminar? 1 🔼 Yas 2 🗌 No	Hospital: 1 ☐ Inpatie	ent 20 ER/Outpat	ient 3□ DOA	26. Placa ot Daa Othar: 4 Nursing H		na) dance 6 Dothar	Specify)		
OIVISION O or Attending Pl after death. Director: After th in by the funera	Certification:	27. Mannar of Death 1 Natural 5 Panding 2 Accident Invastigetion 3 Suicida 6 Could not be determined	28e. Deta of Inju (Month, Da 28a. Plece of Inj building, et	y Year) Injun	M 11	☐ Yas 2 No	Sub	Streat and Number vin, State)	or Rural Routa Number, of Wolest		
To the Hospital within 24 hours To the Funeral	Medical	(Check only 2 Medical Examone)		axamination and/or	investigetion, in my	tima, deta and place, y opinion, deeth occur	red at the tima,	date and place, and	dua to the causa(s)		
D T N T	8 - 4	290. Signature and the of certifier Theoster	U. Ke	of us		o.C.M.E.		JULY 9,20			

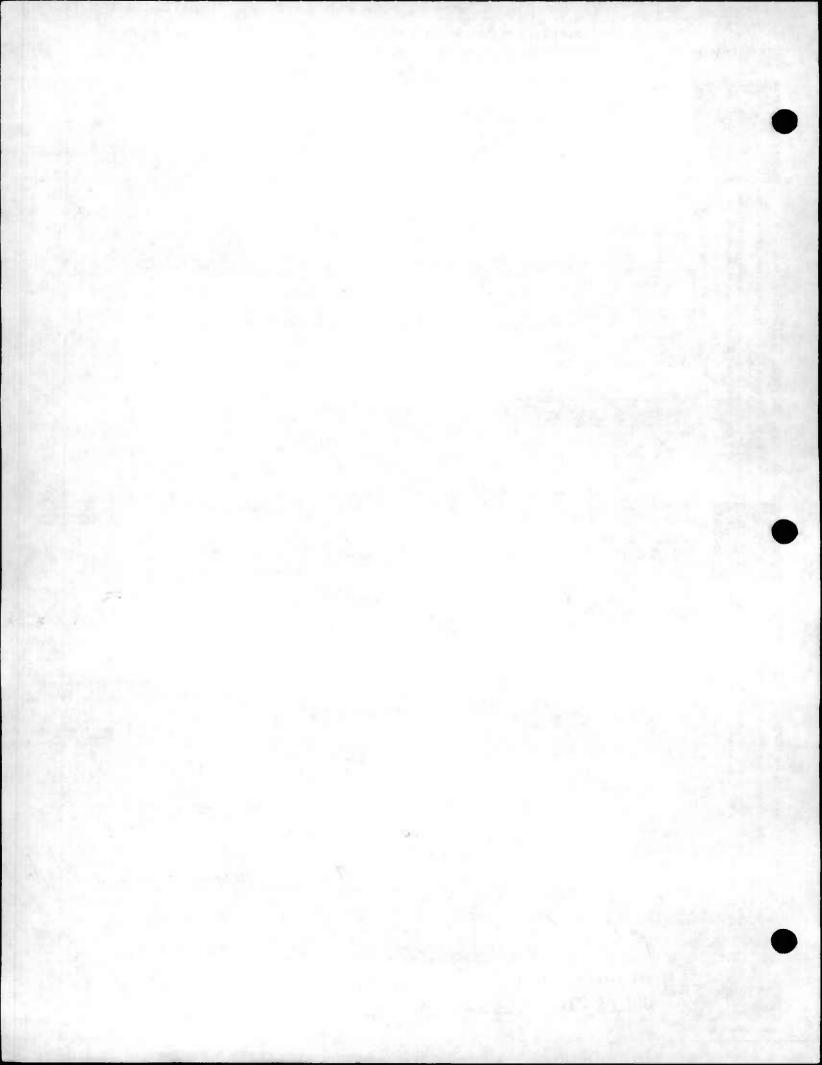
State Registrar

DHMH 16 Rev 6/95

ORIGINAL

32. Registrar's Signatura

111 Penn Street, Baltimore, Maryland 21201



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Ella Swinton 530+ Wh /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of ath 4c. County of Death Examiner Mariner Health Care of Overlea Baltimore NA If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 09-07-07 Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1□M 2√2 F 92 Director 088-28-3151 SC Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits MD 28a-1 st notified Director NA Baltimore X□ Yes 2□ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò items 23a 6116 Belair Road 21206 USA Completed by Funeral 12. Was Decadent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, "natural", or iten edical Examiner Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 □ Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) College (1-4or 5+) Housekeeping Company 3rd. Grade 17. Father's Name (First, Middle, Last) pearmit. Pages 1 and 2 should be tile Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic event ORSe. 18. Mother's Name (First, Middle, Maiden Sumame) Be Jeff Swinton Lula Thompson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rev.Clavon Burston 1216 Woodbourne Avenue Baltimore, MD.21239 20e. Method of Disposition 20b. Piaca of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State XXBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mem. Pk. Cem. 07-13-2000 Randallstown, MD 22. Name end Address of Fecility Baltimore, Maryland 21202 21. Signeture of Funeral Service Licenses Warren WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 72WKS Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed for use as the buriel-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760, physician Due to (or as a consequenca of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. deteched 23b. Dld tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, þ 8 Completed 24a. Was an autopsy performed? 24b. Were eutopsy findings available prior to completion of cause of death? of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28c. injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28d. Describe how injury occurred After ! To the Hospital or Attending within 24 hours effer death.
To the Funeral Director: Aft. 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medicai 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and aftle of cartifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar

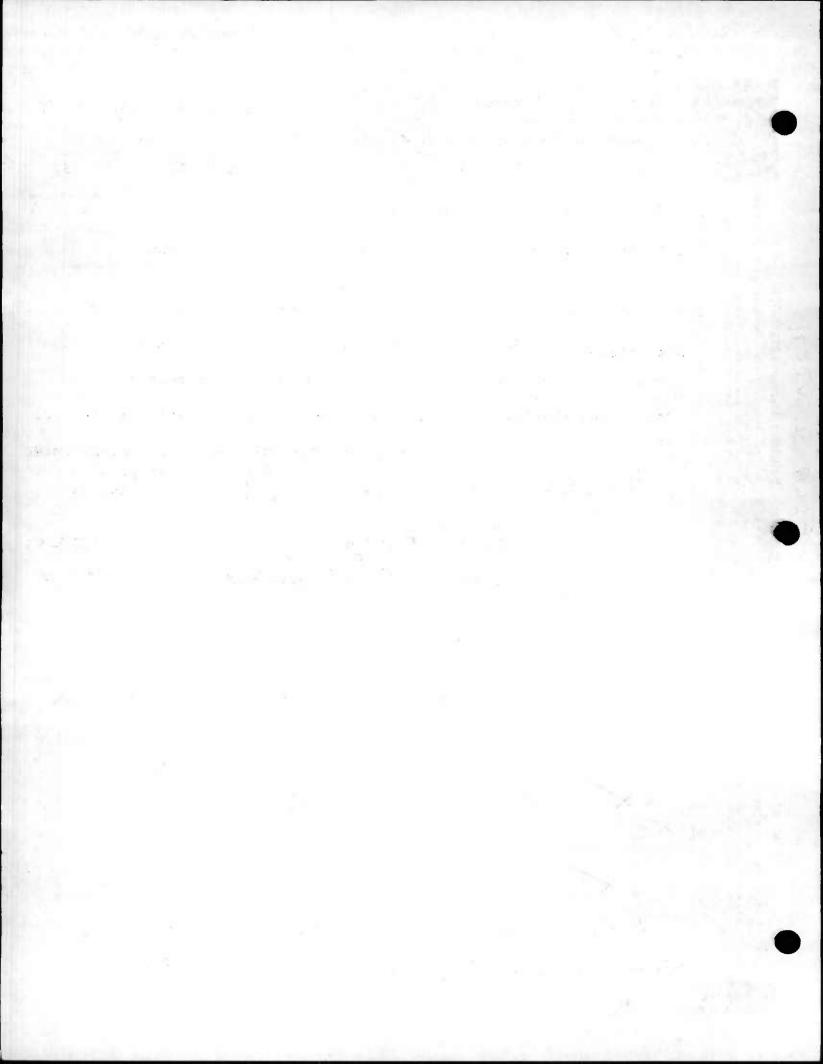
31. Date filed (Month, Day, Year) JUL 12 2000 32. Registrar's Signature

Name and address of person who completed cause of death (Item 23a) (Typa, Print), 5601-Loch Raven Blvd, Baltimore

7-7-2000

MO

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22080 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 500 Am Hury Sessa Charles July 2000 5 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** n/a Baltimore 1807 Ramsay Street

Funeral Director

Baitimore, Maryland 21215-0020

Physician Examiner

To the Hospital or Attanding Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate has been signed by the attending physician and Division of Vital Records, P.O. Box 68760,

5. Social Security Number 212-03-8250 6. Se	x 7. 31.M 2□ F	Age (In yrs.	lest birthdey) Yrs.	If Under Months	1 Yas		der 24 Hr 's Mir	n. (Mo	e of Birth oth, Dey,			thplace (Stete or Foreign ountry) aryland	
Usuel Residence of Decedent								Dec	01,	1,15		<u></u>	
10a. Stete 10b. County		10c. Ci	ty, Town or Lo	ocation								10d. Inside City Limits	
Maryland n/a		В	altimo	re								XXYes 2 □ No	
10e. Street and Number				10f. Zip	Code)			10	g. Citizen of	What Co	ountry?	
1007 Damager Chance						212	23			U.S.A.			
1807 Ramsay Stree	nt Ever in U	S 13	Was Dece	dent o			Specify Ye				ericen Indien,		
1 Never Merried 2 Married 3 Widowed 4 Divorced	Armed Force 1 ☐ Yes 2 If Yes, Give Year or Date	Č(No		If Yes, spe				Specify Ye into Rican, e	etc.)	Specif	ck, White	hite	
15. Decedent's Ed (Specify only highest grad	ucetion de completed)		16a. Dece	dent's Usua	al Occ	upetion le dunna n	nost of w	orkina	1	6b. Kind of B	usiness	Industry	
Elemantary/Secondery (0-12)	College (1-4	or 5+)		kind of wo DO NOT u esman		ired)			F	lakerv	Dis	tributor	
1 1 17. Fathar's Name (First, Middla, Last)	U		Sal	esman		18. Me	ther's No	eme (First		eiden Sumen		CIADACOI	
Rosario Sessa								Magge		eroen ourren	110)		
	111 - 201										-//		
19e. Informent's Name/Reletionship (7)			1	_						City or Town SVille			
Leonard A. Sessa	/ son	20h 1	Plece of Dispo	-			rall	Date		Oc. Location			
1 Burial 2 □ Cremation 3 □	Removel from Sta	ite	cemetery, cre	metory or o	other p	ilece)							
4 Donetion 5 Other (Specify		Dul	aney V				-	7/8/2	2000	Timoni	.um,	Maryland	
21. Signature of Funeral Service Licent	"3un	W	2:	2. Name ar Hubb	ar	d Fun	eral	Home	, Inc	imore	. Ma	ryland 2122	
Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceusa (Disease or injury that initiated events resulting in deeth) Last	b	Due to (d	bacto or es e conse	quence of):		156						years	
Part II. Other significant conditions co	d	h but not res	sulting in the u	underlying	euse	given in P	art f.	23	b. Did tot	acco use co	ontribute	to the cause of death	
Carutid							14-1		1310	8 2□ No	3 □ P	robably 4 Unknow	
Hyper	tension							24	a. Was en		24b.	Were eutopsy findings available prior to completion of cause of death?	
05.11												1 ☐ Yes 2 ☑ No	
25. Wes case referred to medical examinar?	Hospital:					Whor:		eath (Chec	-				
TE TES 212/NO	1 L Inp		ER/Outpatie		JA	4	Nursing	7-		nce 6 Ott		ecify)	
27. Menner of Death 1 Matural 5 Pending 2 Accident Investigation	28a. Dete of I (Month,	Dey Year)	28b. Time of finjury	M	28c, Injury at Work? M 1 Yas 2 No		28d. Describe how injury occurred						
3 ☐ Suicide 6 ☐ Could not be determined					At home, farm, street, factory, office 28f.					f. Location (Street end Number or Rurel Route Number, City or Town, Stete)			
29a. Certifier 1 Certifying Phy (Check only one)	sictan: To the be iner: On the basis end menner	s of examine	owledge, deet etion end/or in	h occurred ivestigation	at the	time, dete	end pleadeath occ	ce, end due curred at th	to the ce le time, de	use(s) end m te end plece,	enner e , end du	s stated. e to the cause(s)	
29b. Signature end title of certifier				29	c. Lice	ense numb	er		29	d. Date signe	ed (Mon	th, Dey, Year)	

State

Registrar

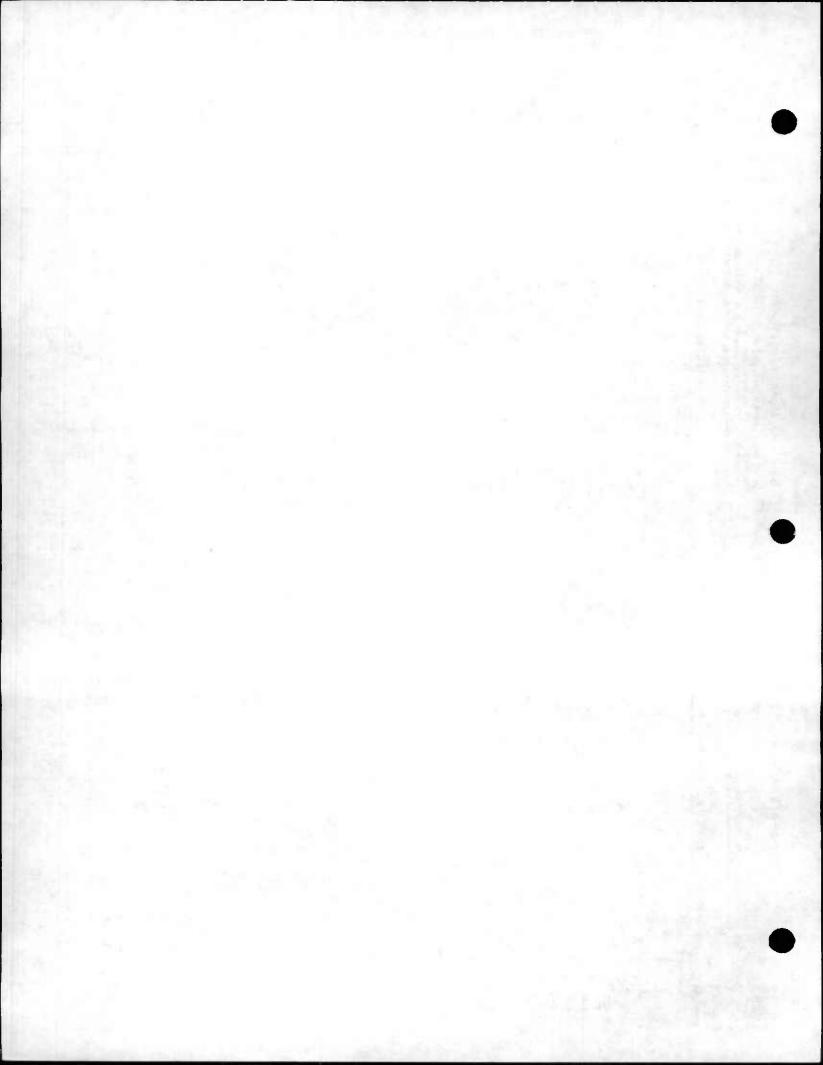
1120 N.

Balt mozizze

ess of pason who completed cause of death (Item 23a) (Type, Print)

2000

32. Registrar's Signature

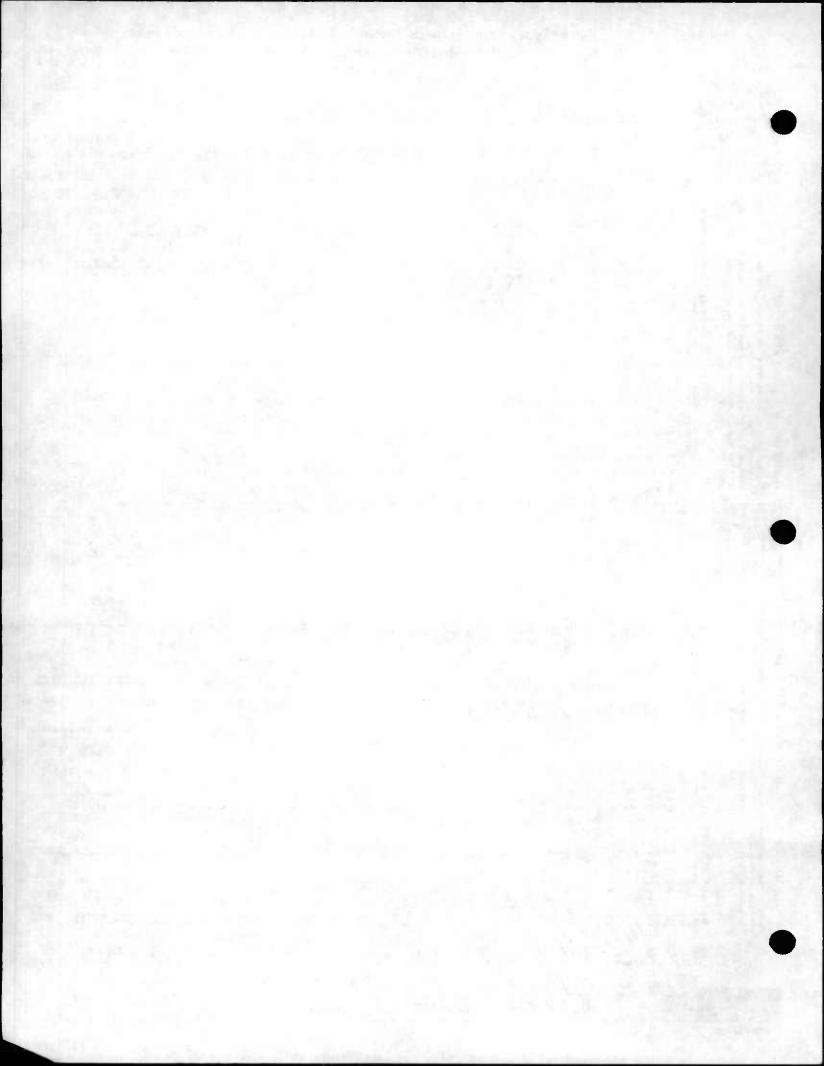


Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2208 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Tima of Deeth **Physician** July 9, Iva Nell Sherman 2000 10:45 pm /Medical 4e Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 1037 Marton Street Prince George Laurel If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Deys 1□M 2\ F 215-40-7161 59 Director May 4,1941 Tennessee Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County show 1 Yes 2 □ No Funeral Director 288-7 Prince George Laurel must be notify 10f. Zip Code 10g. Citizen of What Country? 10e. Street end Number or herrie 23a or 1037 Marton Street 20707 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Rece - American Indian, 11. Maritel Status 12. Wes Decedent Ever in U,S Armed Forces? Bleck, White, etc. the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Merried ☐ Yes 2 No Yes, Give altimore, Maryland 21215-0020 1 Yes 2 No Specify: White þ Specify. 3 Widowed 4 Divorced Yeer or Detes. Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Cashier Retail 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Mental Lutcia Barrette Frank Hickman Department of Health and M Important: If them 27 is mart any Injury or other traumati 265e. 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Eric Sherman/Husband 1037 Marton Street, Laurel, Maryland 20707 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete M Burial 2 ☐ Cremetion 3 ☐ Removel from State Meadowridge Mem. Park 7/13/00 Elkridge, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licensee 22. Name end Address of Facility Fleck Funeral Home, Inc. MO0741 7601 Sandy Spring Road, Laurel, Maryland 20707 muer 23a. Pert1. Enter the diseasa, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Cel CARCINOMA Months Lung Examiner Examine The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting In death) Lesl Due to (or es e consequence of) and Box 68760, physician Physician/Medical Due to (or es e consequence of) for use as Pert II. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. P.O. 23b. Did tobacco use contribute to the cause of death? 2 f ves 2 No 3 Probably 4 Unknown Mellitus of Vitai Records, þ 24b. Were autopsy findings eveilable prior to completion of cause of deeth? Completed 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 20 No Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Neturel 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Locetion (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homlcide To the Hospital or within 24 hours aft To the Funeral DI 29e. Certifier To the best of my knowledge, deeth occurred at the time, date end plece, and due to the cause(s) and menner es steted a: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner steted. completely 29b. Signeture 29c. License number 29d. Dete signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Greenway Ctr. Dr. 1 hom AS Bensinger M 31. Dete filed (Month, Day, State

DHMH 16 Rev 6/95

Registrar

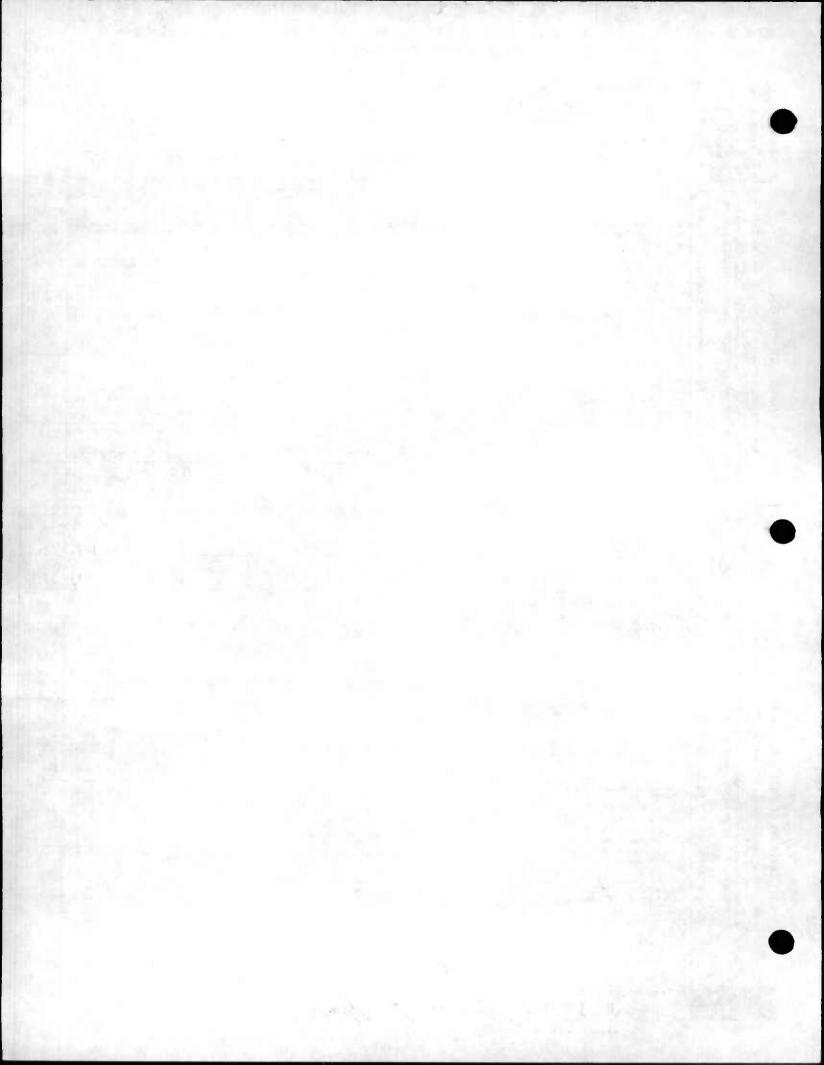


Please Type or Print In Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** CHARLES TAYLOR OLLIDAM 2000 JUL /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner N/A BALTIMORE BAYVIEW MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** Days Months Hours 1 M 2 F 216-86-3095 Yrs 36 Director 02-03-64 MD Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d Inside City Limits item 27 is marked other than "natural", or hems 23s or 28s-f show other traumatic event, the Medical Examinal must be notified at NA MD Baltimore Yes 2□ No Director 10e Street and Number 10L Zin Code 10g. Citizen of What Country? 1534 Abbotston Street 21218 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. permit. Peges 1 and 2 should be filed within 72 hours efter Departmant of Health and Mental Hygiena. Important: if item 27 is marked other than "natural", or the any injury or other traumatic event, the Medical Exempted. 1 ☐ Yes 2 █ No If Yas, Giva Year or Dates: 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: 6 Specify: 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) High Sch. Grad College (1-4or 5+) NA Maintenace Company 17. Fathar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surnama) Be 2 Joseph S. Gray Delores Taylor 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21218 19a. Informant's Name/Relationship (Type, Print) Delores Cook 1534 Abbotston Street Baltimore, 20a. Method of Disposition 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Slete 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Voshell Mem. Gardens 07-13-2000 Dundalk, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH !101 E. North Avenue 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intarval Batwean Onset and Death **Physician** Immediate Cause (Final disease or condition rasulting in death) /Medical PNEUMONIA Examiner Due to (or as a consaquence of): Examiner physician end the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated events rasulting in death) Last Dua to (or as a consequence of): Box 68760 Physician/Medical Due to (or as a consequenca of): 88 950 P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by to 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed peed page 2 certificate has 1 ☐ Yes 1 ☐ Yes 2 ☐ No 25. Was case raferred to medical examinar? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1. Inpatian 2 □ ER/Outpatient 3 □ DOA funeral To the Hospital or Attending Physician 24 hours after death.
To the Funeral Director; After this completely filled in by the funeral 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Panding investigation 1 ☐ Yas 2 ☐ No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, streat, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) end menner stated. edical 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 1-000 JULY 9, 2000 MD EASTERN AVENUE 4940 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AUDREY BALTIMORE, MD 21224 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State 2000 JUL 12 Registrar

DHMH 16 Rev 6/95



Please Type or Print in Black indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22083 AMENDED ITEM #5 PER FH G785 7/12/00 AH Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** 8th CHARLES THIMAN JULY 18:00. 2000 /Medical 4a Facility Name (If not institution, give street end number) LEVINDALE HEBREW HOME 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE N/A If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days XXM 2□ F 215-03-1815 -Director MAY 6 1903 MD. Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A MD BALTIMORE XYes 2 No Director 28a-1 10g. Citizen of Whal Country? 10e. Street and Number 10f. Zip Code b 3307 GLEN AVENUE 21215 USA Nema 23a Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Merital Stetus hours after 14 Never Married 2 Married ь altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: WHITE 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 Elementary/Secondary (0-12) College (1-4or 5+) SALESMAN CLOTHING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Pages 1 and 2 should be next of Health and Mental is marked c **JACOB** THIMAN REBECCA (UNKNOWN) 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) RHEA B. SNYDER/ NIECE 16 WAINWRIGHT DRIVE ANNAPOLIS, MD. 21401 Department of Health a Important: If Item 27 is any injury or other tra 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 X Buriai 2 ☐ Cremation 3 ☐ Removal from State MOGAN ABRAHAM CONGREGATION 7/11/00 ROSEDALE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Euneral Service Licensee 22. Name and Address of Fecility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208

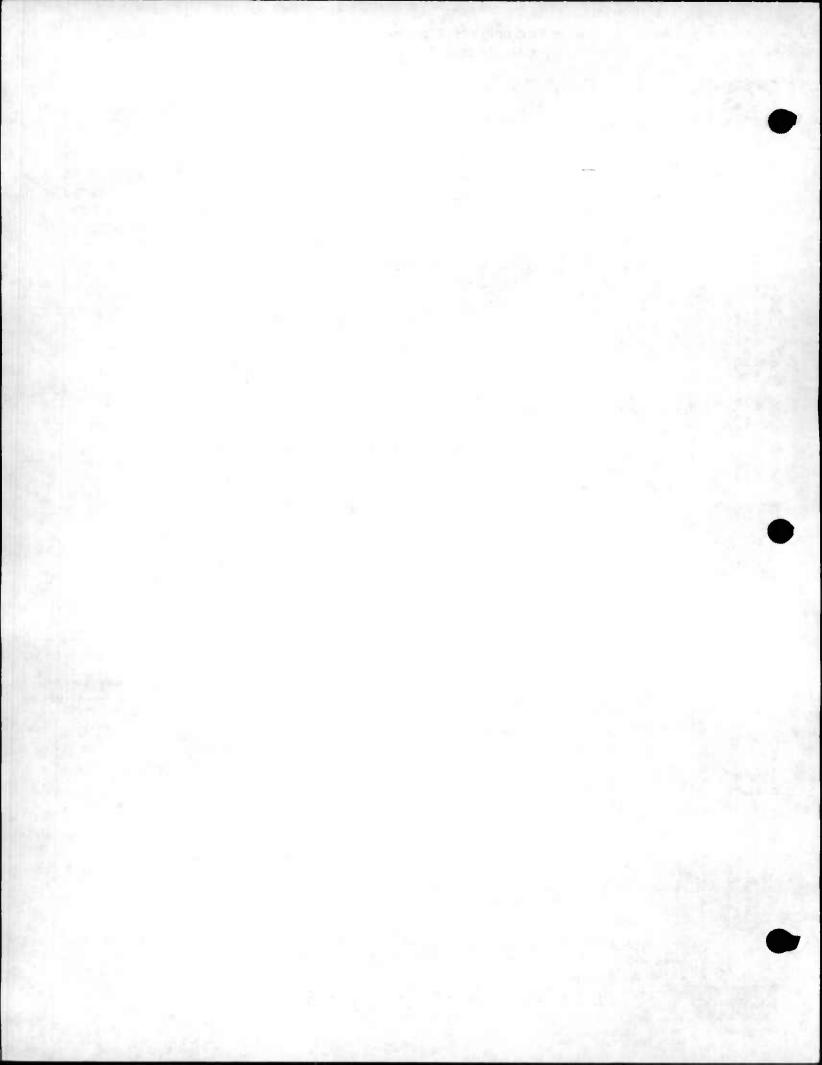
31. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately a proximately a proximate Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) YEARS END STAGE DEMENTIA **Examiner** Due to (or as a consequence of): Examiner DEPRESSION physicien and the buriel-transit certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760 Physician/Medical Due to (or es e consequence of) Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? O 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown نه signed I þ Records, 24b. Were eutopsy findings aveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed The lew hes 2 No 1 Yes 2 No 1 Yes of Vital 25. Was case referred to medical examiner? Be 26. Piece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No this funeral Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. tnjury at Work? 28d. Describe how injury occurred Affer or Attending Division 1 Natural 5 Pending investigation 1 Yes 2 No hours after death. Director: / 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 ☐ HomicIde To the Hospital o within 24 hours aff To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dale and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Homa D0054739 m. tuendey m.D 9th 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) W. Belvedere Avenue, Maryland Baltimore 21215 32. Registrar's Signature State Registrar

Art

DHMH 16 Rev 6/95



Registrar **DHMH 16 Rev 6/95**

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HOL WEST BELVEDERE

BALTIMORE, MD

21215

AVENUE

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

SINAL HOSPITA

32. Registrar's Signard

HEATHER LEE, MD

31. Dete filed (Month, Day, Year)

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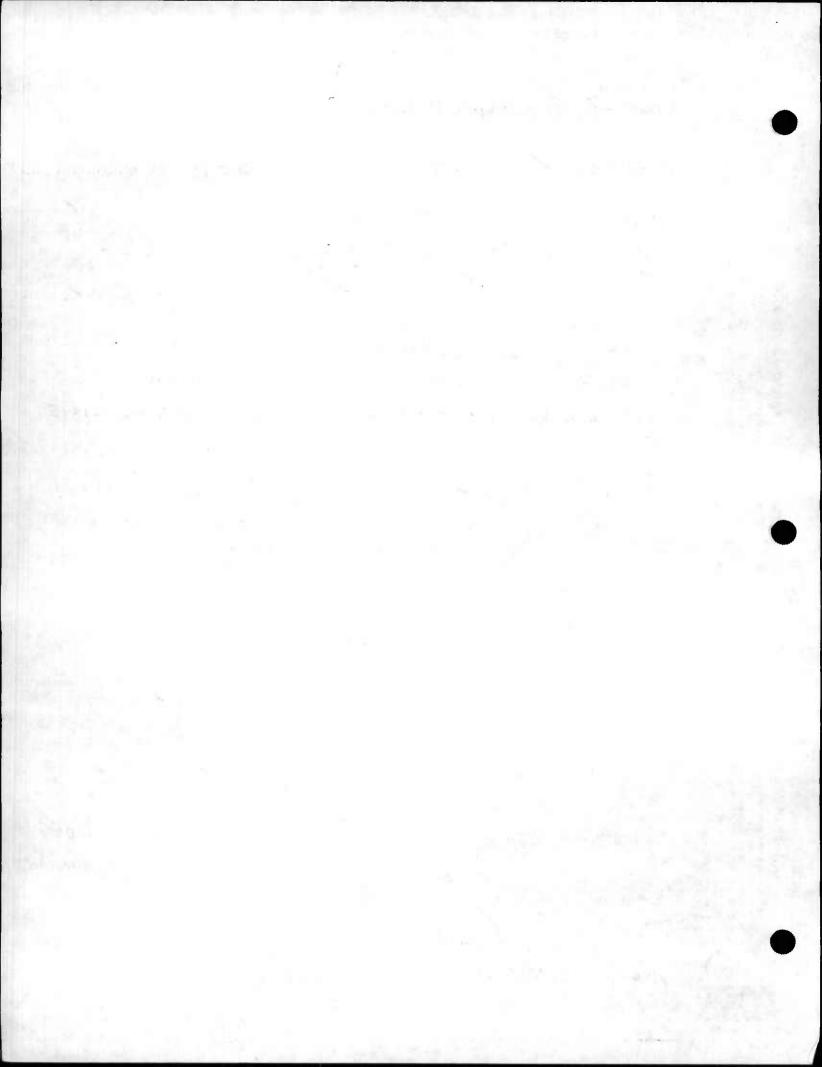
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22086 Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Data of Death Day **Physician** Shirley May Wain 5 2000 0840 July /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Talbot The Memorial Hospital Easton If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2♥F Yrs. Director 60 218-36-5806 Aug 21, 1939 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits flerms 23s or 28s-f show 1 ☐ Yes 2 No Directo Maryland Caroline Federalsburg Hygene, other than "natural", or items 23s or vent, the Medical Examinar must be notifi 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 612 Jacks Lane 21632 U.S.A. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forcas? 11 Marital Status 1 ☐ Yas 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: White Specify: à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Food Preparation Restaurant 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 8 1 and 2 should be Health and Mental is marked Emmett Wilson Nettie Rohrback 2 Pages 1 and 2 should 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Itam 27 George Edward Wain / husband 612 Jacks Lane, Federalsburg, Maryland 21632 altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Department of P Important: If Its 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Cedar Hill Cemetery 7/10/2000 Brooklyn Park, Maryland 21. Signature of Funeral Service Licensee 22. Nama and Addrass of Facility Hubbard Funeral Home, Inc. 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part1. Enter the disease, or shock, or heart failura. List ications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, no cause on each line. Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final atheroscierotic heart disease disease or condition resulting in death) is years **Examiner** The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last dialipses dependent Box 68760. End stage reval devane Physician/Medical Doe to (or as a conse cabetes wellitus ear Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contribute to the cause of death? Division of Vitai Records, P.O. 12 Yes 2 No 3 Probably 4 Unknown Varcular direare. Completed by 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to complation of causa of death? has 2 No 1 Yes 2 NO 1 Yes certificate Attending Physician: Be 25. Was case refarred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No P 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding investigation 1 BNatural n 24 hours after death. e Funeral Director: Aft pletely filled in by the fur 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 6 time Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

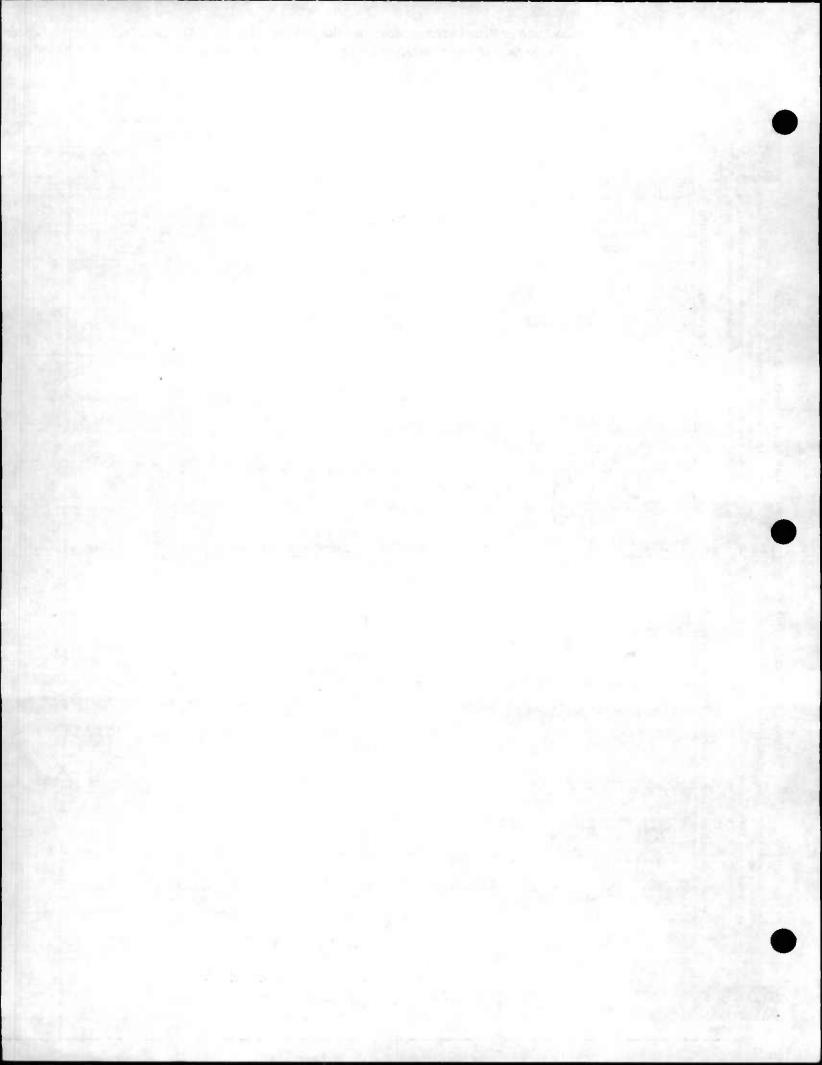
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier completely (Check only one) within 2 \$ 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/5/00 D46020 30. Name and address of person who complated causa of death (Item 23a) (Type, Print) Ali, MD 506 Idlewild Avenue, Easton, Maryland 21601 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

State Registrar

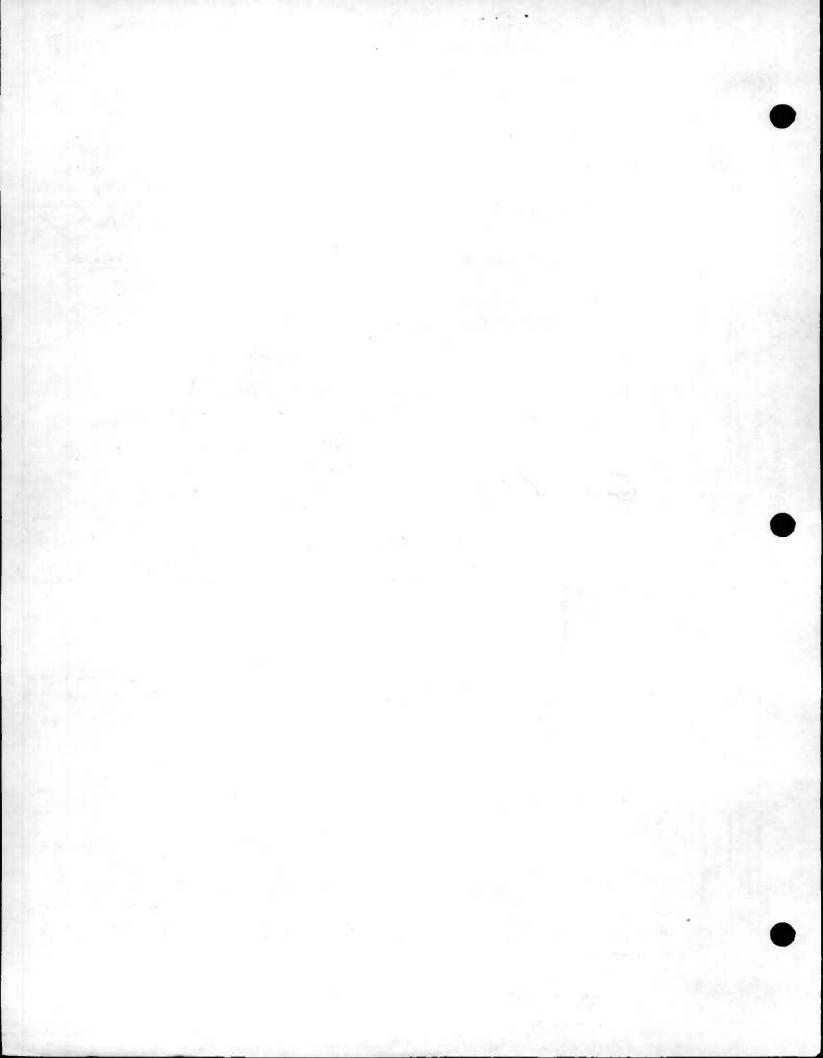
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32. Regist/ar's Signature



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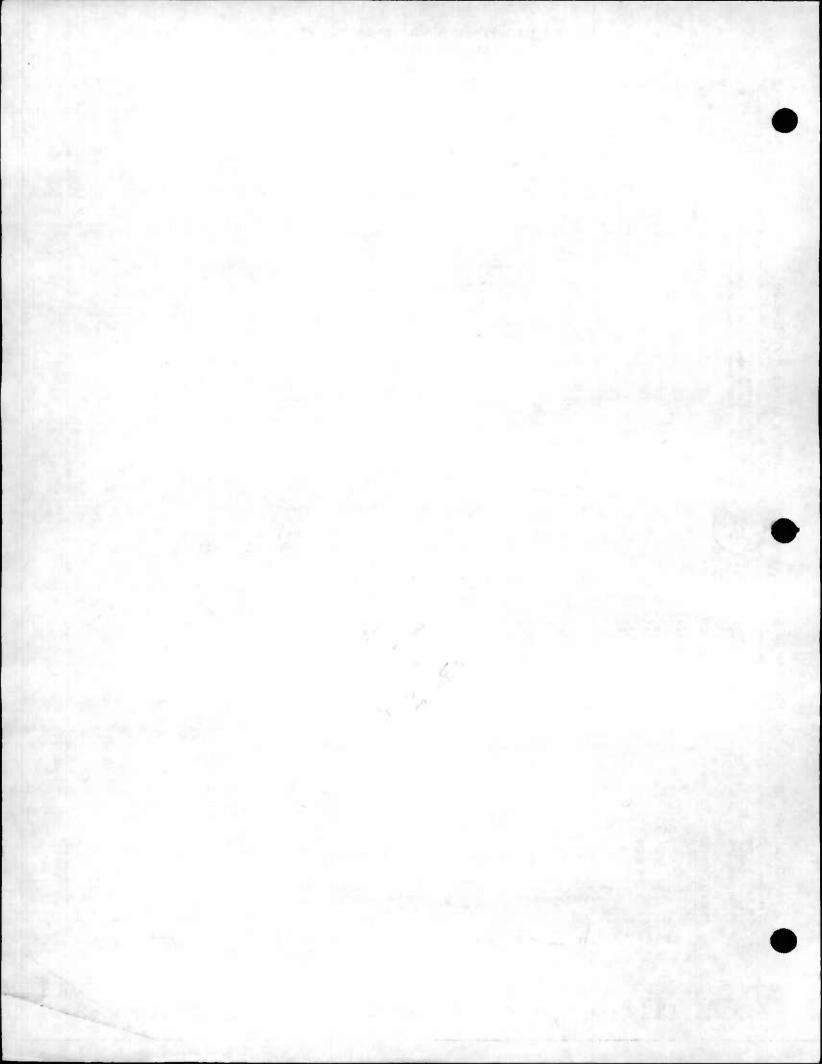
State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 7/7/2000 **Physician** HATTIE WATERS 2:55 AM /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MD. HOSPITAL CLINTON CO. P G 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 4/27/15 9. Birthplace (Stete or Foreign Country)
S.C. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 10 M #0 F Yrs. Director 251 86 8384 85 Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Show 1∰Yes 2□No Directo PRINCE GEORGE MD UPPER MARLBORO 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r rough be n UPPER MARLBORO 20772USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 Never Merried 2 Merried 1 ☐ Yes 2 ∰ No If Yes, Give ¹⁷ Yeer or Detes: 6 1 ☐ Yes 2/ ☐ No Specify: Completed by Specify: BLACK 3€ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) HOMEMAKER permit. Peges 1 and 2 should be filed w Department of Health and Mentel Hygier Important: If item 27 is marked other th eny Injury or other treumstic event, the DRGs. 10 HOME Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be JIM LITTLE MARY LITTLE 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Flural Route Number, City or Town, State, Zip Code) 1631 CHILTON ST. WILLIAM McELVEEN BALTO. MD21218 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Buriel 2 Cremetion 3 Removel from State 4 □ Donetion 5 □ Other (Specify) ARBUTUS PARK 7/14/2000 ARBUTUS MD 22. Name and Address of Facility
ESTEP BROTHERS FUNERAL
1300 EUTAW PL BALTO. MD 21. Signeture of Funeral Service Licensee FUNERAL HOME TO. MD 21217 PA . 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feiture. List only one cause on sach line. **Physician** Immediate Ceuse (Final diseese or condition resulting in deeth) /Medical Examiner Due to (or as a con Pleural effusion Physician/Medical Examiner The law requires that the death certificate be executed for use as the buriel-transit Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury thel Initieted events resulting in deeth) Last Due to (or es e consequence of): P.O. Box 68760, Due to (or es e consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by t 1 Yes 2010 3 Probably 4 Unknown Records, à 24b. Were eutopsy findings available prior to completion of ceuse of death? Be Completed 24a. Wes an autopsy performed? 2 0 No certificate 1 ☐ Yes 1 ☐ Yes 2 ☐ No Division of Vital Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospitel: 1 Depatient 2 ER/Outpatient 3 DOA 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this funaral 27. Menner of Deeth 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After 1 Naturel 5 Pending death. 1 Yes 2 No I or Attendi after death. Director: A investigetion 2 Accident 6 ☐ Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) ne Hospital or Atten 24 hours after de he Funerel Directo pletely filled in by the 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Continuing Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as steted.
2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier Medical To the Hosp within 24 ho To the Fune completely f (Check only one) 29b. Signeture end title of certifier 29d. Date signed (Month, Day, Year) 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Essam DUSSE TELLAWI 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State 2000 ▶ JUL 12 Registrar DHMH 16 Rev 6/95 p 2001



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Baltimore	Pages I nent of H nt: If ite rry or ot	20a. Mathod of Disposition 1 Burial 2 □ Cramation 3 □ Ramoval from State	20b. Place of Disposi cematary, crama	atory or othar place	e)		Location - City or T					
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		30. Nama and eddress of person who completed ceusa of	daath (Itam 23a) (Type, Pr	rint)								
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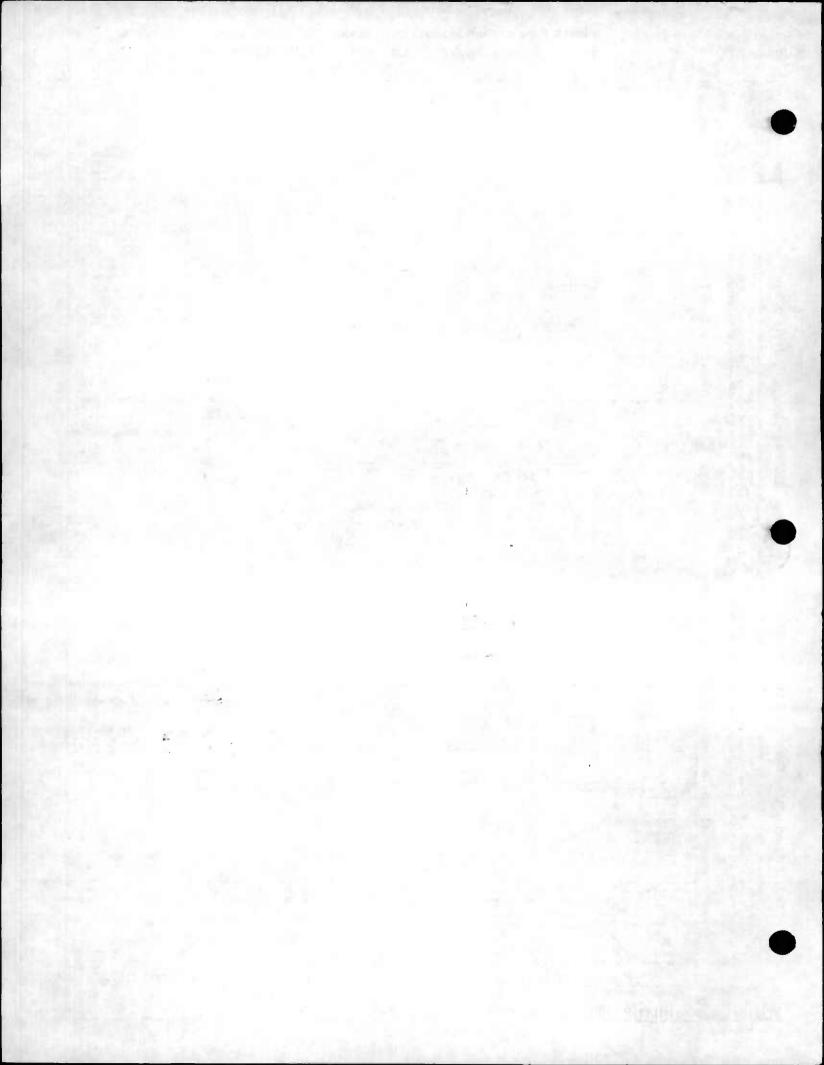
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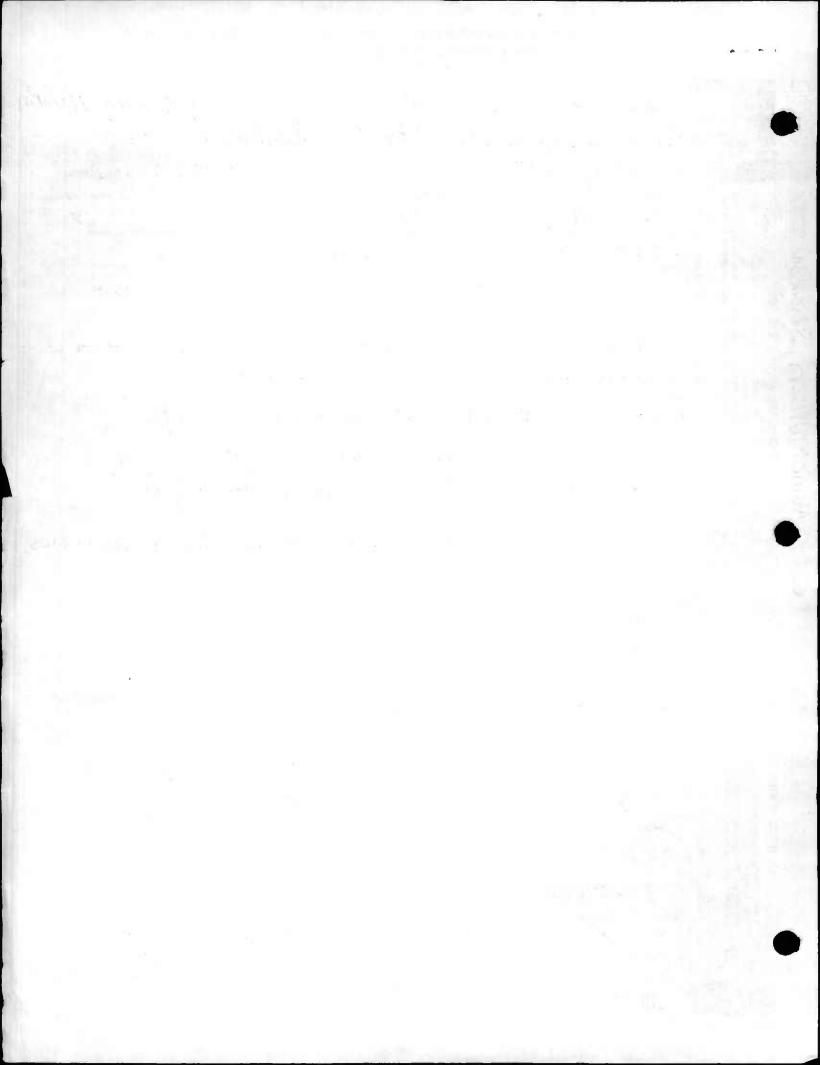
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32. Ragistrar's Signatura

Registrar

JUL 12 2000



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Roger H. Attick 2000 11:06 pm 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Calvert Manor Healthcare Center Rising Sun Cecil If Under 1 Year Months Days Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Yeer) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 XM 2 F 179-12-8550 78 Apr. 11, 1922 Delaware Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1881 Telegraph Rd. USA 12. Was Decedent Ever in U,S. Armed Forces? 1 IX Yes 2 □ No If Yes, Give Year or Dates: WW I I Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Specify: White 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Salesman Lumber 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Roger E. Attick Bessie M. Gross 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Barbara Herr 1235 W. Penn Grant Rd., Lancaster, PA 17603 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Buriat 2 X Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Del Vet Cemetery 7-7-00 Bear, Delaware Tuneral Service Licensee 22. Name and Address of Fecility R. T. Foard Funeral Home, P. A. 111 S. Queen St., Rising Sun, MD 21911 schard -500 23a. Parri. Enter the disease, or comblications the analysed the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause or mach line. Approximate Interval Between Onset end Deeth diate Cause (Final di ese or condition r sulting in death) yegn. Due to (or as a consequenca of): Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. Fibrillalson

Physician /Medical Examiner

and

for

certificate

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director,

þ 8

Completed

Be

7

Certification:

Medical

Records, P.O. Box 68760.

Division of Vital

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

death with the Maryland

permit. Pages 1 end 2 should be filed within 72 hours after death with tha Manylai Department of Health end Manial Hygiena. Important: If itam 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Madical Examiner must be notified as once.

Baltimore, Maryland 21215-0020

Physician/Medical Examiner burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last as use

ongestive Heart Failure

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	1 Yes	2 No	3 Probably	4 🗆 Unkn
24	ia. Was an a	utopsy	24b. Were aut	opsy finding

25. Was case referred to medical examiner?

availeble p completion of death?	
1 □ Vec	2 No

1 Yes No 27. Manner of Death

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

28c. Injury at Work?

26. Place of Death (Check only one) Other: Nursing Home 5 Residence 6 Other (Specify)

2 No

1 Naturel 2 Accident 3 ☐ Suicide

4 Homicide

Veil

5 Pending investigation 6 Could not be determined

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28d. Describe how injury occurred 1 ☐ Yes 2 ☐ No

1 ☐ Yes

(Check only

15 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) and menner stated.

29c. License number

29b. Signature and title of certifier U

31. Date filed (Month, Day, Year)

29d. Date signed (Month, Day, Year)

30. Name end eddress of person who completed backe of death (Item 23a) (Type, Print)

Center Rlaylor MO Calvert Health care

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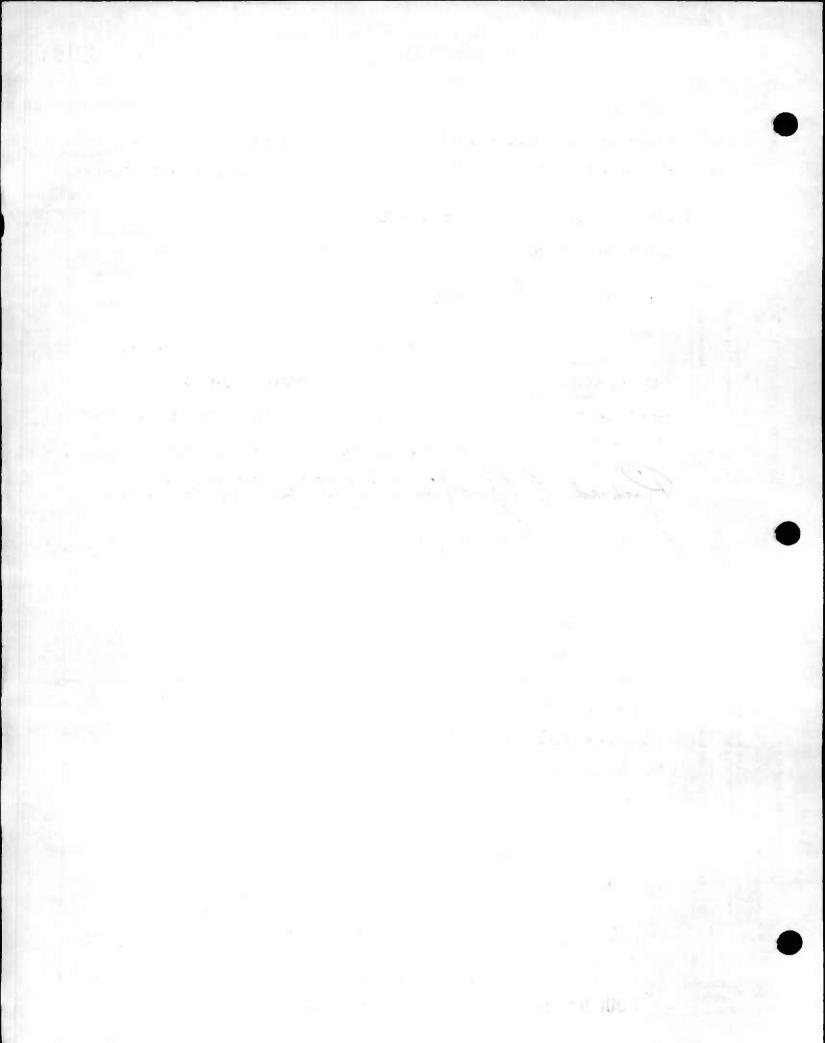
28f. Location (Street and Number or Rural Route Number, City or Town, State)

State Registrar

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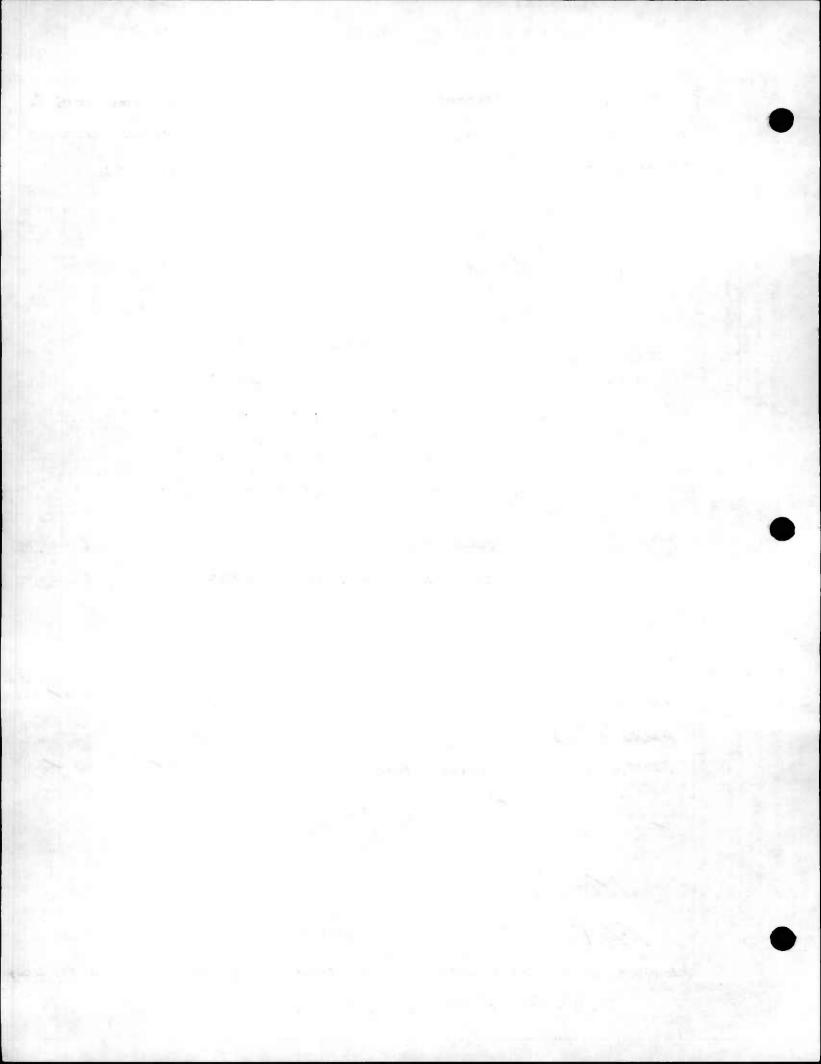
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Year **Physician** BASHAM DOROTHY JUY 1015 2000 /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner REGIONAL GEORGE HOSPITAL PRINCE 5. Sociel Security Number If Under 1 Year | If Under 24 Hrs. 6. Sax 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 10 M 20 F Months Days Hours 217-38-8184 60 Yrs. Director June 17, 1940 Virginia Usual Residence of Decedent deeth with the Maryland 10a. State 10c. City. Town or Location 10d. Inside City Limits show the Medical Examiner must be notified at 1 ☐ Yes 2 No **Funeral Director** Carroll Mt. Airy 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 238 7435 Nathaniel Drive 21771 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No if Yes, Give heme Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritei Stetus 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 ☐ Never Merried 2 ☐ Merried 6 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☑ Divorced Yaer or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Home Maker Unknown Own Home Baltimore, Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be . Pages 1 end 2 should be fil Iment of Health end Mentel H Innt: If item 27 is marked off Harmon Burns Arsula Williams 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health er important: If item 27 is any injury or other trauping. Vance Merson/Nephew 7435 Nathaniel Drive, Mt. Airy, MD, 21771 20b. Ptece of Disposition (Neme of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stets 1 XBurial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/7/00 Elkridge, MD Meadowridge Memorial Pk 21. Signature of Funeral Service Licensea 22. Nama and Address of Fecility Donaldson Funeral Home, P.A. MOO770 313 Talbott Avenue, Laurel, MD, 20707 23a. Part 1. Enter (he disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete intervet Between Onset and Deeth **Physician** tmmediete Cause (Finet diseese or condition resulting In deeth) /Medical CELLULITIS MONTHS Examiner Due to (or es a consequence of): Examiner DISEASE PERIPHERAL VASCULAR MONTHS The lew requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest burial-trer Due to (or as a consequence of). Box 68760, physician by Physician/Medical the Dua to (or as a consequence of): attending pl P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? detached 1 Yes 2 No 3 Probably 4 Unknown ANEMIA Records, 8 24b. Were autopsy tindings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? MALNUTRITION PERIPHERAL certificate ! 1 Yes 2 No 1 ☐ Yes 2 ☐ No RIGHT LUNG Division of Vital Attending Physician: Be 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 2 ER/Outpatient 3 DOA After this apital or Attending Phys hours after death. neral Director: After this y filled in by the funeral d 28c. Injury at Work? 27. Menner of Deeth 28a. Dete of injury (Month, Day Year) Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Interpret 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Yown, Stele) 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled is 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29e. Certifier 29b. Signature and title of certifier. 29c. License number 29d. Date signed (Month, Day, Year) D39629 JULY 2000 6 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) 10724 LITTLE COLLINBIA MD 2001 ALGXANDER SY MD PKWY PATUKENT SUITE 200 31. Dete filed (Month, Dey, Year) 32. Regigiter's Signeture State JUL 0 7 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene | | 22093 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Month **Physician** Brigh asol 1:30 PM JUNE 23 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS 6. Sex CIT Baltimore JOHNS HOSPITAL ALTIMOLE If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral Days Months 1□M 2CXF 205 42 2522 50 Director June 15 1950 Lancaster, PA Usual Residence of Decedent with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. inside City Limits Phone mas 23a or 28a-f short 1 ☐ Yes 2\ XNo Funeral Director PA Lancaster Lancaster 10g. Citizen of What Country? 10e Street and Number 10f. Zip Code 353 Meetinghouse Lane 17601 USA Heme Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours efter 1 Never Merried 2 Married 1 ☐ Yes 2 XNo If Yes, Give 0 21215-0020 1 ☐ Yes 2 No Specify: Specify: White Be Completed by 3 ☐ Widowed 4 ₺ Divorced Yaar or Datas netural 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) School Teacher Education other traumatic evant. altimore. Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health end Mental Important: If itam 27 is marked or any Injury or other traumatic eva Albert Breneman Mary Jane Hess 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Shannon Bright 317 Meetinghouse Lane Lancaster, PA 17601 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20c. Location - City or Town, Stata Date 1 Burial 2 Cremetion 3 Removal from State 4 Donetion 5 Other (Specify) Evans Eagle Crematory | 0/2//00 Leola, FA 1/3-2 22. Name and Address of Facility Harkins Funeral Home Inc. 6/27/00 Leola, PA 17540 21. Signeture of Funerel Service Licensee 600 Main Street Delta, PA Ve 23a. Pert1. Enter the disease, or complications that caused the daath. Do not anter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata intarvei Between Onset and Death **Physician** /Medical immediate Cause (Final sepsis one day disease or condition resulting in death) Examiner Dua to (or as a consequence of): Examine omegalov. NS week buriel-transit The law requires that the death certificete be executed Sequantially list conditions, if any, leading to immediale ceuse. Enter Undarlying Cause (Diseasa or Injury that initiated events resulting in death) Last Graft one month Box 68760 physicien nost Versus Physician/Medical the Due to (or as a consequence of): six months leukemia for use P.O. 23b. Did tobacco use contributa to the ceuse of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records. edical Certification: To Be Completed by 24b. Wara autopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? certificate hes 1 Yes 2 No 1 ☐ Yes 2 No after death.

Director: After this certifica
d in by the funeral director, p Physician: 25. Was case referred to medical 26. Placa of Daath (Check only ona) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Naturai 5 Pending investigation 1 Yas 2 No 2 Accidant 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicida To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dale and piece, end due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, daath occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signeture end title of certifier D0052391 June 23, 2000 ens M 30. Name and addrass of person who completed ceuse of death (item 23a) (Type, Print) Department of Oncology Baltimore, Maryland Johns Hospital HOPKINS ev.s 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State JUN 2 8 2000

DHMH 16 Rev 6/95

Registrar

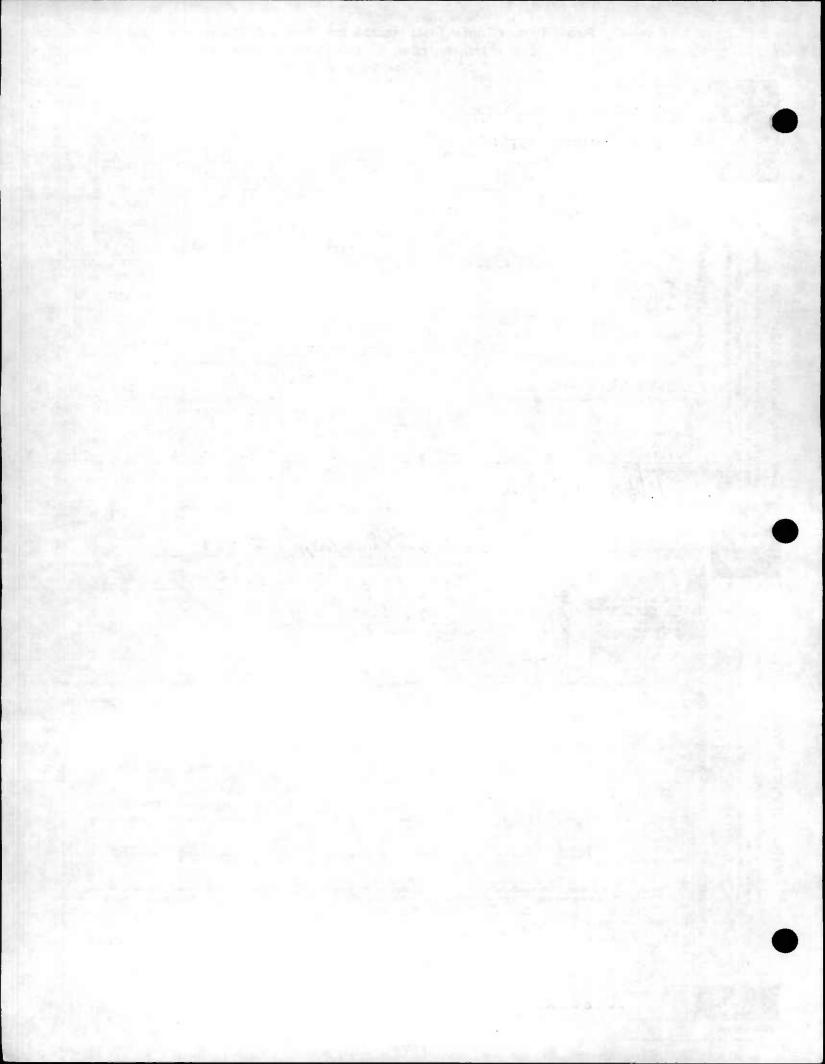
JUNE

State of Maryland / Department of Health and Mental Hygiene 22094 Certificate of Death 2. Date of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) June 22, 2000 **Physician** 7:05p.m. John Walker Bailey, Sr. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Harford Havre de Grace Harford Memorial Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
December 7, 1914Mary1and Birthplace (State or Foreign Country) 7. Age (In yrs. lest birthdey) **Funeral** Days Hours Months 1 XM 2□ F Director 264-01-6214 death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Harford Aberdeen Maryland Directo 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r Maryland 21001 439 Aldino-Stepney Road Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedant Evar in U,S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexicen, Puerto Ricen, etc.) or flams 11. Marital Stetus filed within 72 hours after I ☐ Yes 2 ☐ No If Yes, Give Year or Detes: 1 ☐ Never Married 2 ☑ Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Agriculture Dairy Farmer 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) permit. Pages 1 and 2 should be fitt.
Department of Health and Mental Hy Important, If them 27 is marked other any injury or other traumatic event Be Ella(NMN)Walker Hugh Boyle Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 439 Aldino-Stepney Road Aberdeen, Maryland 21001 Helen Bailey / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stata Data 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Air Memorial Gardens 6-26-00 Bel Air, Maryland of Funeral Service Licegaee 22. Nama and Addrass of Facility McComas Funeral Home, P.A. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest,

Approximately 2.10.09

pproximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finel diseese or condition resulting in death) Examiner Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or injury that Initiated events resulting In death) Last The law requires that the death certificate be execu Box 68760. Physician/Medical Due to (or as a consequence of): USB P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, by 24b. Were autopsy findings available prior to completion of ceuse of deeth? 24a. Was en eutopsy performed? Completed page 2 s 2 PNo 1 Yes 2 No 1 Yes of Vital 25. Was cese referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: 1 Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) edical Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After Division Hospital or Attending 5 Pending investigation death. 1 ☐ Yes 2 ☐ No To the Hospital or Attendit within 24 hours after death.
To the Funeral Director: All completely filled in by the fu 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signaturand fitte of certifiar 29c. Licanse number 29d. Data signed (Month, Dey, Year) elepel D0002654 6-22-00 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) 0 HAVRE LE GRACE, MD. 21078 LUSE 464 Kenjel MD 32. Aegistrar's Signatura 31. Data filed /Montil State 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Month Day June 30, 4b. City, Town, or Location of Death Lois Ann Brown 2000 2055 4a Facility Name (If not institution, give street and number) 4c. County of Death Havre de Grace Harford Memorial Hospital 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplace (Stete or Foreign Country) Months Days 1□ M 201 F Yrs. 212-38-4916 59 July 18,1940 | Maryland Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits 1X Yas 2 □ No Maryland Harford Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 700 West Belair Ave., Apt 232 21001 12. Was Decedent Evar in U,S. Armed Forces? 1 Yes 2 10 No H Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No. If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian. 11. Marital Status Black, Whita, alc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: Black 3X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Physical Therapist Hospital 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) George Waldon Jr. Doris Pugh 19a. Informant's Name/Retationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 Rush Chapel Road, Aberdeen, MD 21001 ace of Disposition (Name of Data 20c. Location - City or Town, Stata Kem Cooper / Son 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Mathod of Disposition 1 ☐ Buriat 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Union United Methodist 7/5/00 Aberdeen, Maryland 21. Signature of Funaral Service Licenses 22. Nama and Addrass of Facility Lisa M. Scott Funeral Services Des 2 cett 552 Lewis Street, Havre de Grace, MD 21078 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Intervat Between Onsat and Death

Physician /Medical Examiner

Physician/Medical Examiner þ

for use as the buriel-transit The law requires that the death certificata be axecuted Division of Vital Records, P.O. Box 68760, to the Funeret Director: After this certificate has been signed by the scompletely filled in by the funeral director, page 2 should be detached to Attending Physician: this After within 24 hours after death. To the Funerel Director: A b

Be Completed Medical Certification: To

25/Was case referred to medical examiner? 27. Manner of Death

State Registrar

Physician

/Medical

Examiner

10a. Stata

Directo

Funeral

ò

Completed

Be

Funeral

Director

the Maryland

permit. Pages 1 end 2 should be flied within 72 hours after death with the Maryla Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show entry injury or other traumatic event, the Medical Examiner must be notified an once.

Maryland 21215-0020

Baltimore,

Brown

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Pert II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given in Pert I.

1 Yes 20 No

1 Natural 2 Accident

3 Suicide

29a. Cartifier (Check only one)

4 Homicide

Immediata Causa (Final diseasa or condition rasulting in death)

5 Pending

investigation 6 Could not be detarmined

Inpatient 2 ER/Outpatient 3 DOA

Place of Injury - At homa, farm, street, factory, office building, atc. (Specify)

28b. Tima of

Due to (or as a consequence of):

Due to (or as a consequence of):

Dua to (or as a consequence of)

-CREDING MERHETHURS

28c. Injury at Work?

1 Yes 2 No

24a. Was an autopsy

24b. Were autopsy findings available prior to completion of causa of deeth?

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

29d. Data signed, (Month, Dey, Year)

1 Yes

28d. Describe how injury occurred

1 ☐ Yas 2 No

26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stele) Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the ceuse(s) and menner as stated.

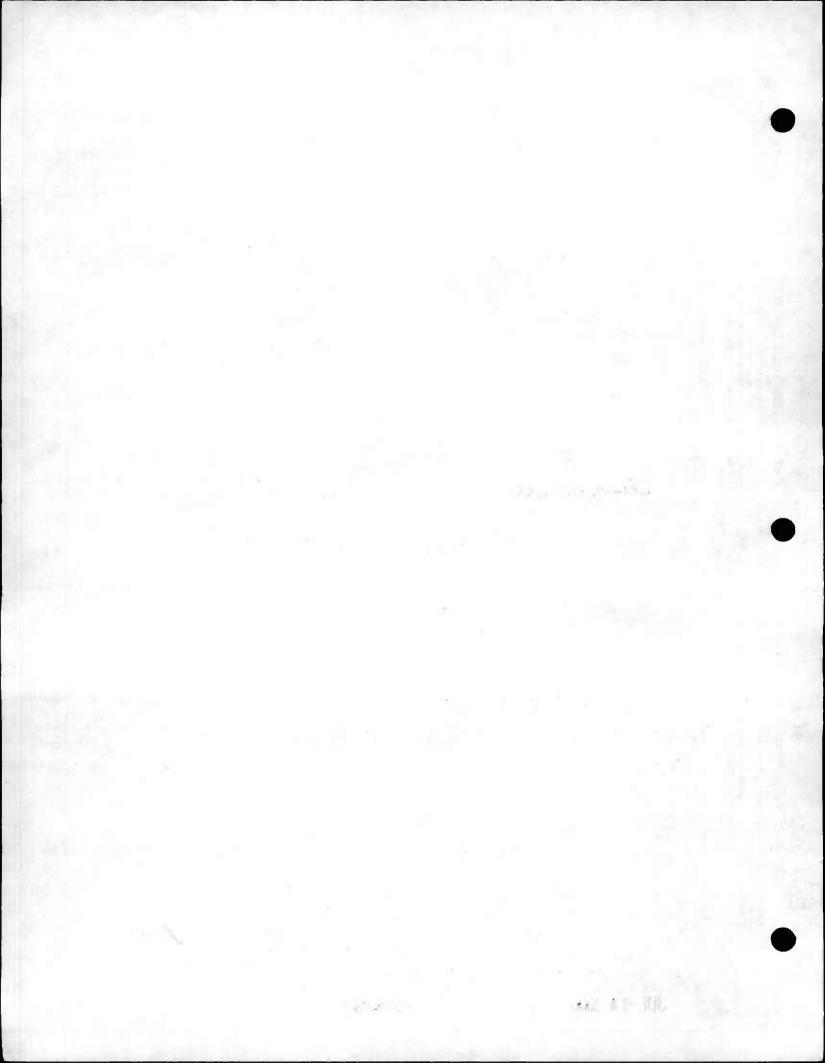
2 Medical Examiner: On the basis of axaminetion and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated.

29b. Signature and titla of certified 29c. License number

32. Registrar's Signatura

30. Neme and addrass of person who completed cause of death (Item 23a) (Type, Print) SUMION

31. Date filed (Month, Day, Year) JUL 0 3 2000



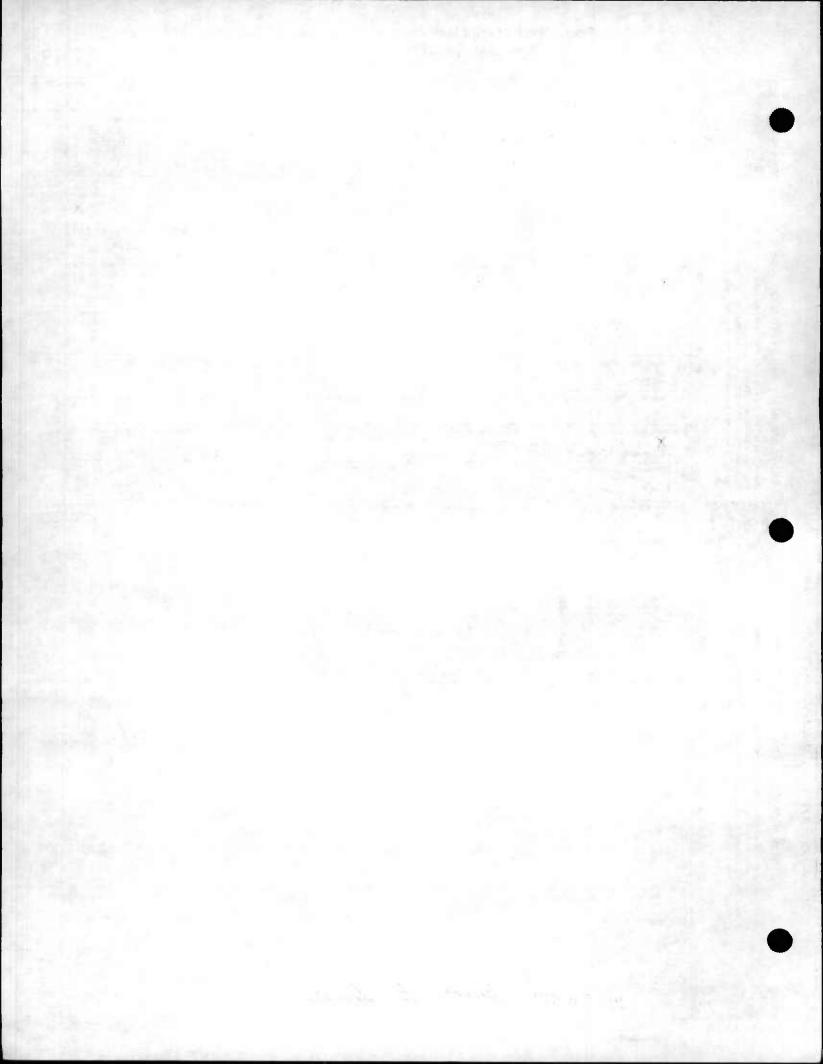
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.

cian						of Death			Reg. No.		
cian	Decedent'a Name (First, Mide	die, Last)			2. Date of De	ate of Death		3. Tima of D			
	Tyrrell Je	anine	Bullock	10.				Month Tubi	Day	Year 2000	2305
lical iner	4a Facility Name (If not institution					4b. City, T	own, or Lo	ocation of Deeth		ty of Death	
11101	PENINSULA REG	TONAL ME	EDICAL CEN	VTER		SA	LISB	IIRY	WI	COMIC	20
	5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1	ear If Unde	er 24 Hrs.				place (State or i
r r	218-06-1445 Usuel Residence of Decedent	1□M 2	(F 36	Yrs.	Months E	Peys Hours	Min.	8. Date of Bird (Month, Da Dec. 29	1963	Mary	land
	10a. State 10b. Count	ty	10c. C	ity, Town or Lo	ocation					1.	10d. inside City
ত	Maryland Wi	aomi ao		C-14-	b						1XYes 2
act.	-	comico		Salis					10- 04	1140-04 000	
Completed by Funeral Director	10e. Street and Number 10f. Zip Code								10g. Citizen o		ntry r
<u>e</u>	408 Lake St	reet				21801			U.S.A		
e l	11. Meritat Status	12. Was	Decedent Ever in U ed Forces?	J,S. 13.	Was Decedent If Yes, specify	t of Hispanic C Cuban, Mexic	rigin? (Sp en, Puerto	ecify Yes or No Rican, etc.)	- 14. Ra	ace - Americack, White,	
正	1 Never Married 2 ☐ Ma	rried 1 []	Yes 2 No		1 Yes 2				Spec	ih.	
5	3 ☐ Widowed 4 ☐ Divorced If Yea, Give Year or Detes:								Black		
ě	15. Decede (Specify only high	ent's Education	eted)	16a. Dece	dent's Uauel C	Occupation	nst of work	ina	16b. Kind of	Business/in	dustry
음	Elementary/Secondary (0-12)		ege (1-4or 5+)	life.	(Give kind of work done during most of working life. DO NOT use retired)			y			
E	12			Do	mesti	C			None		
Be	17. Father's Neme (First, Middle	e, Last)			11-15-3-	18. Mot	her's Nem	e (First, Middle,	Maiden Sume	eme)	
	Andrew Ston	6				Ada	Bu 1	lock			
2	19a. informant's Neme/Relation		el	10h Maiti	ina Addrage /S			al Route Numb	er City or Tow	n State 7ii	n Code)
2										77, 01010, 24	0000)
	Lester Bullo	ck (BLC					ISDU	ry, Md		- Chu - T	Ciata
	20a. Method of Disposition 1 Burial 2 Cremation	3 DRemoval		cemetery, cre	osition (Name matory or othe	r place)	1	Dete	20c. Location	n - City or 1	own, State
	4 □ Donation 5 □ Other (Sp	ringh	ill Me	em.Gar	den	124/00	Hebro	n.Md	
	21. Signature of Funeral Service	e Licensee				Address of Fed Fune					
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	um m	7- 686	my	_				sbury		001	Approximete
	23a. Pert1. Enter the diseese, shock, or heart feilure. Li	st only one ceuse	e on each ine	un. Do not en	iter the mode c	n dying, such c	13 Cardiac	or respiretory a	11030,		tnterval Betwee
1				1 -	^		0			+	Oriset and De
	Immediate Cause (Finat	1	MIX								
	disease or condition	T	NUN DID	talle	KNU	dest	(0			1	3 W
		a	Due to (or as a conse	equence of):	leist	Ca			1	3 W
Je .	disease or condition	a	Due to ((or as a conse	equence of):	less	Ca		167		3 W
	disease or condition resulting in deeth)	a	Sepsi			leis	Ca				3 W
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	disease or condition resulting in deeth) Sequentially list conditions, if any, teading to Immediate cause. Enter Underlying	a	Sepsi. Due to (or es a conse	quence of):	leis	Ca				3 W
	disease or condition resulting in deeth)	a b c	Sepsi. Due to (quence of):	leis	Ca				3 W
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Medical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any, teading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	a b c d	Sepsi. Due to (or es a conse	quence of):	léis	Ca		6,4		3 W
Medical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any, teading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events	a b c d	Due to ((or es à consec	quence of):	dus Segiven in Par	11.	23b. Did	tobacco uss o	contributs	3 W
Medical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	a b c d	Due to ((or es à consec	quence of):	dus Sagiven in Par	(0)		tobacco uss o		
Medical Examiner	disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last	a b c d	Due to ((or es à consec	quence of):	se given in Par	11.		N		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth Month **Physician** CHARLES BARKSDALE JR FULTON JUNE 177 2000 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO 8. Dete of Birth (Month, Day, Year) If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 225-56-8292 55 December 14,1944 Virginia Director Usual Residence of Decedent the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits -1 ☐ Yes 2 X No Maryland Wicomico Salisbury Directo al', or itema 23a or 28a-f Exercises must be notifie 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21804 30766 Johnson Road USA Funeral 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Meritei Stetus 72 hours after 1 Yes 2X No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Peges 1 and 2 should be flied within 7 nent of Health and Mental Hygiene. ant: If Item 27 la marked other than "r ury or other traumatic event, the Med Elementary/Secondery (0-12) College (1-4or 5+) 12 Fork Life Operator Webcraft 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Charles Fulton Barksdale Sr. Helen Mawyer 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 30766 Johnson Rd., Salisbury, MD 21804 Deloris J. Barksdale/Wife 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 20e. Method of Disposition Department of Important: If it any injury or c 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 6/21/00 Salisbury, MD 21804 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 21. Signature of Funeral Service Licensee 22. Name end Address of Fecility Holloway Funeral Home Professional Association M01051 501 Snow Hill Rd., Salisbury, MD 21804 (Dompson 23e. Pert1. Enfer the disease, or complications that caused the deefh. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediata Cause (Finel Premona disease or condition resulting in death) Examiner Due to (or es e consequenca of): Examine Osstructivi Lum physician and s the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Lest Due to (or es e consequence of): 68760 certificate be Physician/Medical Due to (or es a consequence of): USB 23b. Did tobacco use contribute to the cause of death? Pert II. Other afgnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. Ö 1 Yes 2 No 3 Probably 4 Unknown ۵ Records, þ 24b. Were eutopsy findings evailable prior to completion of ceuse of death? 24e. Wes an autopsy performed? Completed has page 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No certificate of Vital Be 25. Wes case referred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1 Inpatient 2□ ER/Outpatient 3□ DOA Medicai Certification: To After this To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After it completely filled in by the funeral 27. Menner of Death 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. Injury et Work? 28d. Describe how injury occurred Division 1 Netural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) end menner steted. 29e. Certifian 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 118/00 mo 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) Dr. Stephen Pavios 56d Riverside

31. Dete tiled (Mohin, Dev. Year)

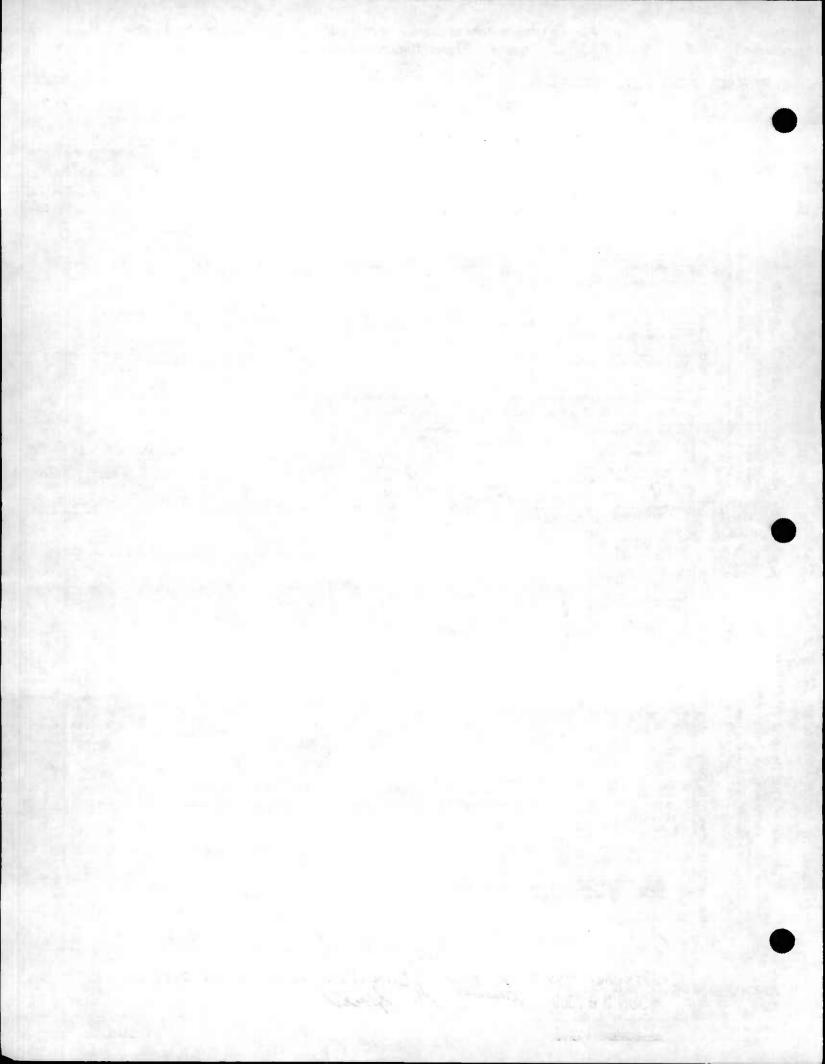
JUN 20 2000

Se Registrars Signetures Drive Blog, Jalisbury Md 21801 State Registrar

DHMH 16 Rev 6/95

225-56-8292

BARKSDALE



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22098

	Decedent's Name (First, Middle,	Last)		Certificate of		2. Date of D			3. Time of Death	
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Examiner	4a Facility Name (If not institution,				4b. City, Town, or Location of Death 4c. County of Death					
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Funeral Director	5. Social Security Number 410 05 6098 Usual Residence of Decedent	3. Sex 7. Ag	ge (In yrs. lest birth	Months Davs		8. Date of B (Month, D JUNE]	irth Pay, Year) 19,1919	9. Birthple Count TENNI	ace (State or Foreign ry) ESSEE	
Mend Mend	10a. State 10b. County	7 7 7 7 7	10c. City, Town	or Location				10	d. Inside City Limits	
Man	MARYLAND ANNE AR				1 ☐ Yas 2 🕅 No					
er death with the Marylen thems 23e or 28e-f ehow ner must be nettred at unerst Director	10e. Street and Number					10g. Citizen of V	Vhat Count	ry?		
23a	1705 OLD TOWN RO	AD		21037			UNITED S	STATES		
urs off	3 ☐ Widowed 4 ☐ Divorced	If Yes. Give		13. Was Decedent of If Yes, specify Cut		No- 14. Race - American India Black, White, etc. Specify:WHITE		itc.		
72 h natu	15. Decedent's (Specify only highest		16e. 0	Decedent's Usual Occu Give kind of work done ife. DO NOT use retire	pation during most of wo	orking	16b. Kind of Ba	siness/ind	ustry	
led within 72 ho lyglene. her then "neturn it, the Wedler!!	Elementery/Secondery (0-12)	College (1-4or	5+)	ife. DO NOT use retire E CONTRACT					RUCTION	
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d 2 should be the and Mente 7 to marked traumatic	19a. Informant's Name/Reletionship	19b. l	Mailing Address (Stree			ber, City or Town,	Stete, Zip	Code)		
	BESSIE M. BOOHER	(WIFE)	170	5 OLD TOWN	ROAD E	DGEWATER	R,MD.2103	37		
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/Medical Examiner	Immediate Cause (Final disease or condition	Rosp	10000	ch fai	1416	0			Days	
	resulting in death)	· Kesp	Due to (or es e co	ensequence of):						
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Month 3. Time of Death Year Dorothy Christine Christensen 26 UNE 2000 4e Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Lorien Nursing & Rehabilitation Center Belcamp HARFORD If Under 24 Hrs. 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year) Birthplaca (Stata or Foreign Country) 1□ M 2 F Days 224-24-3546 Jan. 23, 1923 West Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Maryland Harford Churchville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 111 Calvary Road 21028 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐No If Yes, Give Yeer or Detas: 11. Maritel Stetus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Race - American Indien, Black, White, etc. 1 ☐ Never Merried 2 ☐ Married 1 ☐ Yes XXNo Specify: Specify: 3XXWidowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementery/Secondary (0-12) 12 College (1-4or 5+) Homemaker Own Home 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Hiday U/K Sprouse Ressie Drewsilla Gragg 19e. informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 104 Village Greene Lane, Baltimore, Maryland 21220 lace of Disposition (Name of Data 20c. Location City or Town, Stete Linda L. Herzberg-daughter 20e. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) XX Burial 2 Cremation 3 Removel from Stete Bel Air Memorial Gardens June29,2000 BelAir, Maryland 4 ☐ Donetion 5 ☐ Othar (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signeture of Juneral Service Licensee 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Pert1. Enjer the disease, or complication, the caused the death. Do not enter the mode of dying, such es cardiac or respiratory arrest, shock, or heer teilura. List only one cause on aech line. Immediate Cause (Final disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Lest Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. tribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown 24b. Were autopsy findings aveilable prior to completion of cause of death? 24a. Wes en eutopsy performed? 2 No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Place of Deeth (Check only one) Other: 4 vursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA 27. Manner of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation 1 Yes 2 No 2 Accident

Examiner The lew requires that the deeth certificate be executed Box 68760, P.O. | Records, certificate of Vital Hospital or Attending Physician: this After Division death. after death

Physician/Medical Examiner physician s the buria for use as þ ate has been signe page 2 should be Be Completed director Certification: To illed in by the 24 hours a

Physician

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filed within 72 hours after Hygiene.

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Important: If item 27 is m any injury or other traum once.

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State Registrar

6 Could not be detarmined

3 Suicide

29a. Cartifiar

4 Homicida

29b. Signature and Mile of certifie

29c. License numbe

1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data end place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and due to the cause(s) end mannar stated. 29d. Daty signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

use of deeth (item 23a) (Type, Frint) eval

istrar's Signature

28e. Plece of Injury - At home, farm, street, fectory, office building, atc. (Specify)

120

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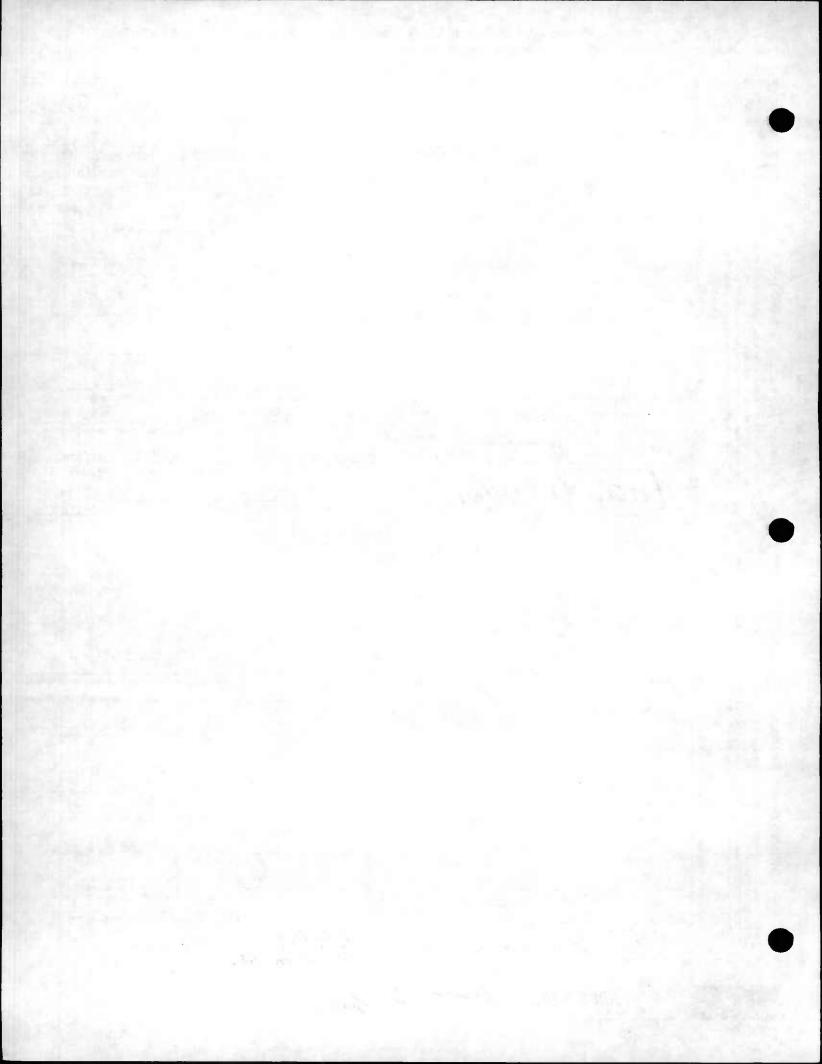
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	e dea the at ned fo	Physician/I	Part II. Other significant conditions con	tributing to death bu	t not rasulting in tha ur	ndartying causa giv	ran in Part I.	23b. Did tol	pacco usa contribu	ta to the cause of death?
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N C	Ing P	lon	27. Manner of Death 1 ☑ Netural 5 ☐ Panding	28e. Data of Injur (Month, Day	y 28b. Tima of Injury	28c. Injur Wor		28d. Dascribe ho	w injury occurred	
Division	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical complataly illied in by the funeral director.	Certification:	2 Accidant Invastigetion 3 Sulcide 6 Could not be 4 Homicide determined	28a. Piaca of Inju	ry - At home, farm, stra (Specify)		Yes 2□No	28f. Location (Str. City or Town,		Rural Route Number,
Ω	To the Hospital or Attent within 24 hours after deat To the Funeral Director: completely filled in by the		29a. Cartifiar 1 Certifying Phys	ician: To the best o	f my knowiedga, daath	occurred at tha tin	na, data and place,	end dua to tha ca	usa(s) and mannar a	as stated.
	the Hi sin 24 the Fu	ledicai	one) 2 Medical Examin	nar: On the basis of and manner state	axamination and/or inv	estigetion, in my o	pinion, death occur	red at tha tima, da	ta and place, and du	ia to tha cause(s)
	To t Com	Σ	29b Signatura and titigen camillar	ward	> mos	29c. Licens	a number		d Dete signed (Mor	
	15		30. Nente and address of person who co	mpleted cause of de	eth (Item 23a) (Type, I	Rrint)	112 BM	2 AIR	ROAD	7,2000 AND 21047
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Day Month Year **Physician** 2325 Harold Henry Collins June 20 2000 /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner WICOMICO SALISBURY PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 10XM 20 F 78 Director 216-16-7770 Maryland Usual Residence of Decedent death with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. inside City Limits show 1 Nes 2 No Director Maryland Worcester Berlin 23a or 28a-f 10a. Street and Number 10f. Zin Code 10g. Citizen of What Country? 102 Flower Street 21811 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 1 Yes 2 No If Yes, 3 No Year or Dates: 1942-1945 or items Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: þ Specify: 3 Nidowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 11th self-employed laborer Landscaping Company Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 end 2 should be fill Department of Health and Mentel Hy Important: If item 27 is marked oth any injury or other traumatic avant Be Ernest Collins Bethards 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Neme/Relationship (Type, Print) Sheila Gortman/daughter 4589 Penny Tree Place - Chantilly, VA 20151 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Paul Church Cemetery 6/24/00 Berlin, Maryland 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21. Signature of Funeral Service Licensee JOLLEY MEMORIAL CHAPEL 21801 23a. Pert1. Enter the disease, or complicators that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one/cause on each line. Approximate interval Between Onset and Death **Physician** immediate Ceuse (Finel disease or condition resulting in death) /Medical Zules Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) Box 68760. Physician/Medical the the Due to (or as a consequence of): USB Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the ceuse of death? 3 Probably 4 Unknown 1 Yes 2 Ale Records, Completed by 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? paga 2 1 Yes 2 No 1 ☐ Yes 2 ☑ No of Vital 25. Was case referred to medical examiner? luneral director Be 26. Piace of Death (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) Hospital: Medical Certification: To 1 Yes 2 No 1 Anpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending s atter oc. 1- Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide Hospital within 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated. 29a. Certifier completely (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 154879 30. Hams and address of person who completed cause of deeth (Item 23a) (Type, Print) Greg Treuth . M.D. 23 2000 32. Resstrar's Signature

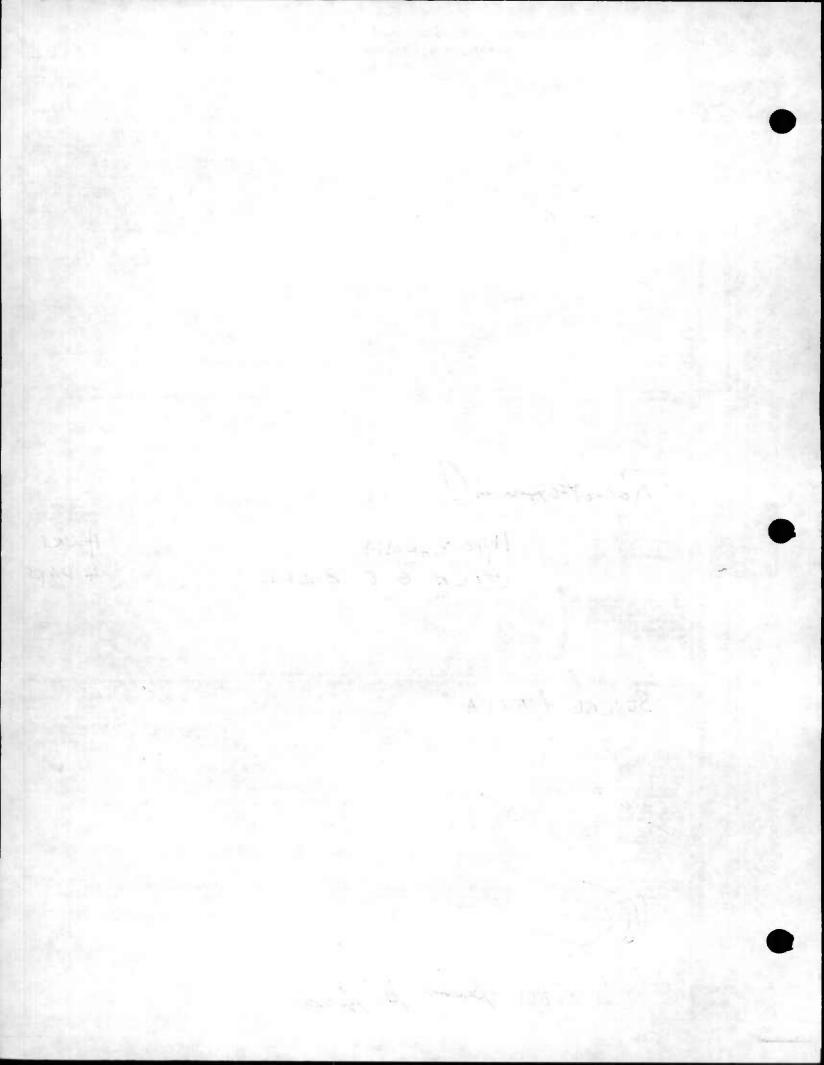
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State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 22102

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RICHARD HASTINGS					ELEANOR	WEST			
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22103. Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** JULIE DOWD JUNE 2020 7 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** SALISBURY WÍCOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 1 Year | If Under 24 Hrs. Months Deys Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) August 8, 1929 Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 XF 70 Yrs. 499-32-9663 Director Missouri Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1K Yes 2 No Director Maryland Wicomico Fruitland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? b 412 Forest Drive 21826 must b USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No if Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Meritel Stetus Bleck, White, etc. 1 Never Married 2X Married b 1 Yes 2 No Specify: Specify: þ White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Technical Librarian Chemical Industry 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Pages 1 and 2 should be t nent of Health and Mental I ant: If Item 27 is marked of Wasil Dobrovolsky Maria Yanchek 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) Richard H. Dowd/Husband 412 Forest Dr., Fruitland, MD 21826 20b. Place of Disposition (Neme of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition r piace) Department of P Important: if for injury or c 1 Burial 2 □ Cremetion 3 □ Removal from State Wicanico Memorial Park 6/22/00 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Holloway Funeral Home Professional Association Keit 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart failure. List only one cause on bech line. **Physician** immediata Cause (Final disease or condition resulting in death) /Medical duys Examiner Due to (or as a consequence of) MO Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Physician/Medical Due to (or as e consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 Probably 4 Unknown Records, δ 24a. Wes en autopsy performed? Were autopsy tindings evailable prior to Be Completed completion of cause of deeth? page 1 Yes 2 No 1 Yes of Vital after death.

Director: After this certifications 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death Injury at Work? 28d. Describe how injury occurred Division Neturel 5 Pending Investigation Injury 1 Yes 2 No 2 Accident To the Hospital or Attar within 24 hours after des To the Funeral Director completely filled in by th 3 Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and placa, and due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29d. Date signed (Month, Dev. Year)

gic

Registrar

29b. Signature and title of certifier

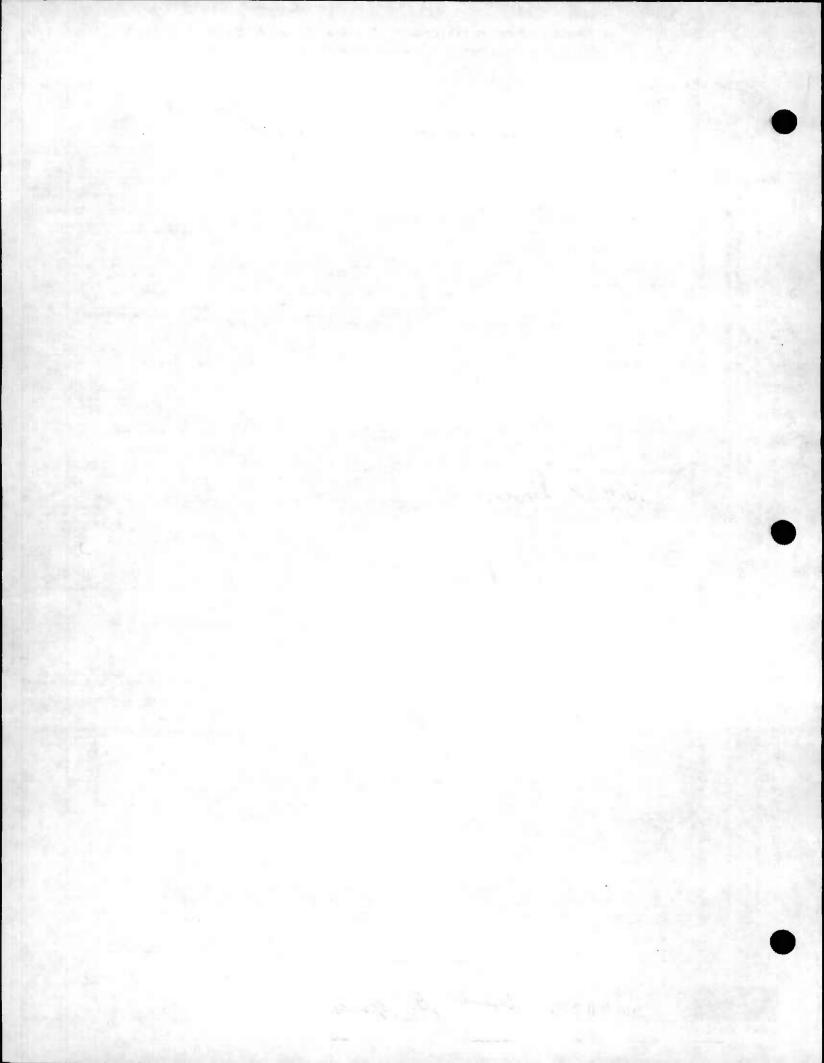
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30. Name end address of person who completed cause of death (Item 23a) (Type, Print)

145

29c. License number

SAUSBURI



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

	State	•	Certificate of Death	Reg. No.	10 22104
Physician /Medical	Decedent's Nama (First, Middle, Last) DNET Facility Name (If not institution, give street and	LANCIS	SWING 4b, City, Town, or	2. Data of Death Month Day JUN 23 2	Yaar COO 14=50 443
Examiner		-AL HOSPI			1 FO ~ 1)
Funeral Director	5. Social Security Number 209-30-1074 Usuat Residence of Decedent	7. Age (In yrs. last birthd	(ay) If Under 1 Year If Under 24 Hrs	8. Data of Birth	Birthplaca (Stata or Foraign Country) Pennsylvania
ylend	10a. Stata 10b. County	10c. City, Town o	r Location		10d. Inside City Limits
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after death with the Maryler or items 23s or 28s-f show miner must be notified at the Purpers Director	10e. Street and Number 207 Fairwood Road		10f. Zip Code 21014	10g. Citizen of USA	What Country?
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Maryis d 2 should th and Mer to marke traumate	19a. Informant's Name/Relationship (Type, Print)		ailing Address (Street and Number or R		Stata, Zip Coda)
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Baltimore, permit. Pages 1 at Depertment of Heal Important: If News eny Injury or otherane.	21. Signature of Funeral Service Licensee	HILLTON	22. Name and Address of Facility	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th	, raryraid
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Division of To the Hospital or Attending Physical Within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral director Medical Certification: To	(Check only 2 Medical Examiner: On the	the best of my knowledge, do ne basis of axamination and/or manner stated.	eath occurred at the time, data and place r investigation, in my opinion, death occu	e, and due to the causa(s) and m urred at the time, date and place,	annar as stated. and due to the cause(s)
To the To the comp	29b. Signature and title of certifier	^	29c. License number	29d. Data signe	d (Month, Day, Year)
	- yourship who	In DMI		9 JUN 2	3, 2000
15	30. Name and address of person who completed	cause of death (Item 23a) (Tyr	Λ	MO 21014	
State Registrar	31. Data filed (Month, Day, Year) JUN 2 6 2000	2. Registrar's Signature	South		

State of Maryland / Department of Health and Mental Hygiene 22105. Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** June 26 Jerry 2000 /Medical 4a Facility Name, (If not institution, give, street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** of Maryand Medecay BAHIMORE stems 7. Age (In yrs. last birthday) If Under 1 Yeer | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 8. Date of Birth (Month, Dey, Year) **Funeral** 1₩ M 2□ F Director 9/29/1928 West Virginia 161-20-4840 deeth with the Marylend 10a. State 10d. Inside City Limits 10b. County 10c. City. Town or Location ahow the Medical Examiner must be notified at 1 XYes 2 No Funeral Director 28a-f Harford Whiteford 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 9 1505 Main Street Herne 23a 21160 United States Race - American In Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Merital Status filed within 72 hours after 1 X Yes 2 □ No
If Yes, Give
Yeer or Detes: WW 2 & 1 Never Merried 2 Married 21215-0020 ò 1 ☐ Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 Divorced natural Korea_{16e.} Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Superintendant of Bldgs. Civil Service Department of Health and Mental Hygie Important: if Item 27 is marked other the any injury or other treumatic event, the DOGS. 10 Baltimore, Maryland 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Dewey Farley Leafie Blake 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Dorothy O. Farley - Wife 1505 Main Street, Whiteford, MD 21160 20b. Pieca of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Date 1 Burial 2 Cremetion 3 Removal from State Slate Ridge Cemetery 6/30 4 ☐ Donetion 5 ☐ Other (Specify) Delta, PA 21. Signeture of Funeral Service Licen 22. Name end Address of Fecility Harkins Funeral Home, Inc., Delta, PA ou the disease, or combilications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, heart feilure. List only one ceuse on each line. Approximate tnterval Between Onset end Deeth **Physician** fmmediate Cause (Finel disease or condition resulting in death) /Medical hour Examiner Due to (or es e consequence of) Be Completed by Physician/Medical Examiner use as the burial-transit The lew requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es e consequence of): Sub MARCHMOUL HEMORRHAGE Box 68760. aneous Due to (or es a consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown of Vital Records, 8 24b. Were eutopsy findings available prior to completion of cause of deeth? 24a. Wes en eutopsy performed? this certificate has 2 No 1 Yes 2 No 1 Yes or Attending Physician: 25. Wes case referred to medicat examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Menger of Death 28b. Time of 28d. Describe how injury occurred Division After 5 Pending investigation 1 Neturel 2 Accident Injury after death.
Diractor: Aft
d in by the fur 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pleca of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homicide within 24 hours a Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and piece, end due to the ceuse(s) and menner as stated.

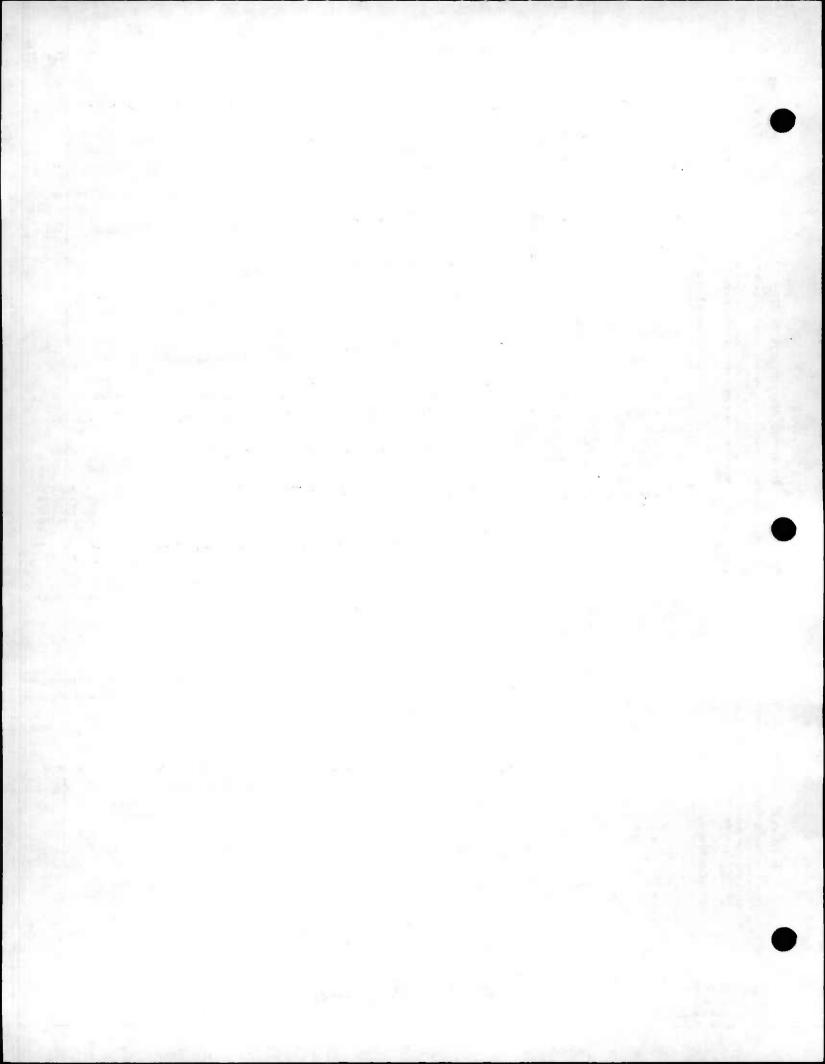
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end piece, end due to the ceuse(s) and menner stated. 29e. Certifier completely \$ 29b. Signatus 29c. License number 29d. Date signed (Month, Dey, Year) AU4176935R12450 ess of person who completed cause of deeth (Item 23e) (Type, Print) Ram; 8ima 12 South 32. Pegistrer's Signeture State 2000 Registrar

MN 28 2000 James

State of Maryland / Department of Health and Mental Hygiene 22106 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** 2000 10:45 AM ELIZABETH SHIRLEY FUGETT July /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 7550 Bensville Road Waldorf Charles If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. lest birthdey) Birthplece (State or Foreign Country) **Funeral** Deys 10MXXF Months Yrs 72 Director 284-24-8073 June 24, 1928 Kentucky Usual Residence of Decedent with the Maryland 10a. Siele 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 Tho Directo Charles Waldorf Maryland 10e. Street and Number 10f. Zip Code 10a, Citizen of Whel Country? Nema 23a HSA 20603 7550 Bensville Road Funeral permit. Pages 1 and 2 should be filed within 72 hours effer deat Department of Health and Mental Hyglene. Important: if them 27 Is marked other than any injury or other travers. t4. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Specify: White 1 Yes 2 No Specify. 2 3√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Neme (First, Middle, Maiden Sumerne) 17. Father's Neme (First, Middle, Last) Be Virginia Bradley Carter 2 Roy Carter 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 7550 Bensville Road Waldorf, MD 20603 Elizabeth S. Griffith (Daughter) 20b. Plece of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stele 20a. Method of Disposition Date 1 ☐ Buriai 2 ☐ Cremetion 3 ☐ Removal from State 4-5-00 Louisa, Kentucky 4 DonAllon 5 Other (Specify) Bradley Cemetery 21, Signature of Faherel Service Licensee 22. Neme end Address of Fecility Eberwein Funeral Services M00173 4433 White Pls. La. White Pls., MD 20695 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Finel disease or condition resulting in death) Breast Cancer **Examiner** Due to (or es e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last buriel-tran and Due to (or es e consequenca of) Box 68760. physicien Physician/Medicai Due to (or es e consequence of) for use as the signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown þ 24a. Wes an autopsy performed? 24b. Were autopsy findings evailable prior to Completed completion of cause of deeth? page 2 certificate hes 1□ Yes XZX No 1 Yes 2 No or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpalient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home XX Residence 6 Other (Specify) edicai Certification: To 1 Yes 2XXVo After this funeral 28a. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division XXNatural 5 Pending investigation s after death. f Director: Aft of in by the fur 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - Al home, farm, street, factory, offica building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Puneral L Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steled. 29a. Certifier completaly (Check only one) 29c. License number 29d. Dale signed (Month, Dey, Year) 29b. Signeture end title of certifier D28352 July 3, 2000 30. Name end address of person who completed cause of deeth (Item 23e) (Type, Print) Krishan Mathur, MD., P.O. Box 1703, La Plata, MD 20646 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUL 0 3 2000 Registrar

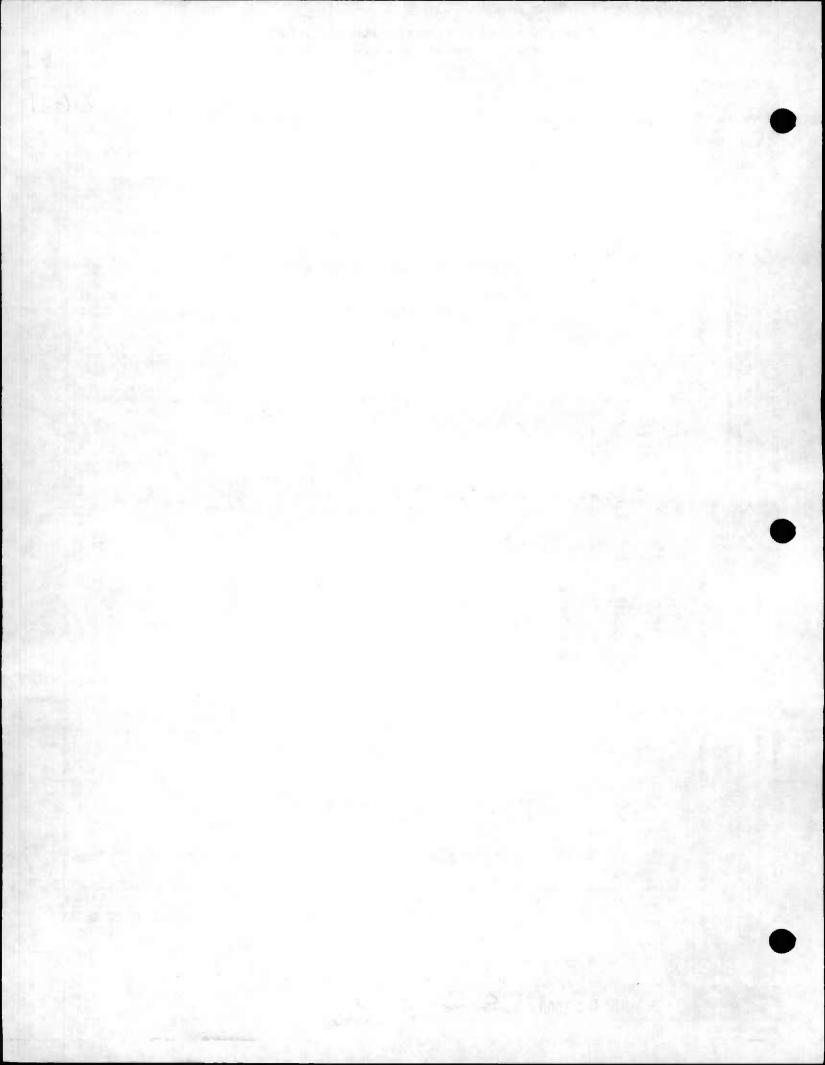
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** PETER 20th 2000 4:15 am FREEMAN June /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Wicomico Salisbury Wicomico Nursing Home Hours Min. 8. Date of Birth (Month, Day, Year)
OCT . 21, 1923 If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 1 X M 2□ F 76 Yrs. 092-20-7786 Director CALIFORNIA Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits r 28a-f show 1 ☐ Yes 2X No Director MARYLAND WICOMICO WILLARDS 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? à munt be 238 36029 COBBS HILL ROAD 21874 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 [∆Yes ≥ □ No If Yes, Give Year or Dates: 1944–46 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married natural, or 1 ☐ Yes 2 No Specify: Specify þ 3 ☐ Wildowed 4 ☐ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ENGINEER CONSULTING 17. Fathar's Name (First, Middia, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be STUART **FREEMAN** MONICA SHARRETTS 19a. Informant's Neme/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health an important: If them 27 is DOLORES T. FREEMAN/WIFE 36029 COBBS HILL ROAD, WILLARDS, MARYLAND 21874 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) SUNSET MEMORIAL PARK 6/23/00 BERLIN, MARYLAND 21. Signature of Funeral Service Licent 22. Name and Address of Facility HASTINGS FUNERAL HOME, SELBYVILLE, DE. 19975 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Approximate Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of) burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequence of): Box 68760. Physician/Medicai that initiated events resulting in death) Last the Due to (or as a consequence of) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 25 No 3 Probably 4 Unknown à Records. 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? certificate lue 1 ☐ Yes 2 1 No 1 ☐ Yes 208 No Division of Vital i or Attending Physician: after deeth. Director: After this certifica Be 25. Was case referred to medical examine? 26. Place of Death (Check only one) Other: 4™ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ EP/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 5 Pending investigation 1 Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital Within 24 hours a To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only 29b. Signafure and title of certifier 29d. Date signed (Month, Day, Year) regon 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) 5302 Chingberry Drive Salisbury MD 21801 Belloso, MD Gregorio State Registrar



State of Maryland / Department of Health and Mental Hygiene

00 22108

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В.	K.	S		

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	Atten or deat octor: by the	Certification:	2 Accident invastigation 3 Suicide 6 Could not be 4 Homicide determined	6-33-3000	ome, farm, str	vn]Yes 2風No	Street and Number	ror Ryral Royla Number,				
	Hospita 4 hours Funerel tely fille	edicai Ce	(Check only 2 Medical Exam	Motor yelclan: To the best of my kno niner: On the basis of examina	Vehic wledga, daath tion and/or inv	h occurred at tha t	ima, data and place opinion, death occ	Anne A	rundel Co	ounty, Marylan			
	To the Hos within 24 ho To the Fun completely	N N	one) 29b. Signatura and title of certifier	and mannar stated.		29c Licer	se number		29d Data signed	(Month, Day, Year)			
	₽ ₹ ₽ 8		Stust 1	(Nad	M.M.		.M.E		JUNE	24, 2000			
			30. Name and address of person who	completed causa of death (Jen	n 23a) (Type,	Print)							

State Registrar

Stephen 5: 31. Date filed (Month, Day, Year) JUN 2 7 2000 111 Penn Street, Baltimore, Maryland 21201

300 7 7 2000 T 5 1900

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 2 2 1 1 0

			(Certifica	ate of	Death		Re	g. No.	, (m	2110
	1. Decedent's Name (First, Middle,	Last)						Dete of Deeth Month	Day	Yeer	3. Time of Death
Physician /Medical	Anne Madylen	Gillinger						une 18	2000	1001	11:30 A.M
Examiner	4e Facility Neme (If not Institution,	give street and number)				4b. City, Tov	wn, or Location	on of Death	4c. County	of Death	
	94 Waterwhee	Drive				Port	Depos		Cecil		
Funeral Director	123-01-3386	5. Sex 7. Age ((In yrs. last birth 87 Y	day) If Unc Month	der 1 Year s Days	If Under a	Min. Ju	Date of Birth Month, Day, LLY 24,	Yes() 1912	9. Birthp Coun Penns	laca (State or Foreign try) sylvania
P .	Usual Residence of Decedent 10a. State 10b. County	F •	IOc. City, Town	or Location						1	0d. Inside City Limits
Maryla f sho	MD Cec			Deposi	t						1 X Yes 2 No
or 28a-1 s or 28a-1 s be notified Director	10e. Street and Number			-	Zip Code			10	og. Citizen of V	What Coun	try?
130 or	94 Waterwheel	Orive			21	904			U.S.	A.	
s. 1 and 2 should be filed within 72 hours after death with the Maryland fleating and Merial Hygiene. The fleating and Merial Hygiene. To Be Completed by Funeral Director To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Marrie 3 XWidowed 4 Divorced	12. Wes Decedent Ev Armed Forces? 1 ¼ Yes 2 □ No If Yes, Give Year or Dates:			cedent of I pecify Cub 2 X No		gln? (Specify , Puerto Rica	Yes or No- an, etc.)	Blac	e - Americ ck, White, c	etc.
led within 72 hor ygiene. Nor than "nature it, the Mid call Completed	15. Decedent's (Specify only highest	Education	16a. [Decedent's U	sual Occup	pation	of working	1	16b. Kind of Bu	usiness/inc	dustry
mple	Elementary/Secondary (0-12)	College (1-4or 5+)		Give kind of life. DO NOT		d)	or working				
Hygier the Cor	12	0		Homema	ker				In hom		
1 and 2 should be filed with leath and Mental Hygiene. am 27 is marked other than ther traumatic svent, the M To Be Comp	17. Father's Name (First, Middle, L. Vincent Des							ne Pav	faiden Suman	10)	
should ind Men	19a. Informant's Name/Reletionship		19h	Mailing Addre	ass (Street				City or Town,	State. Zin	Code)
and 2 s ealth ar n 27 is er trau	Gary Zeigler (-					osit, M		1904
r Heat tam other	20a. Method of Disposition	scep granase.	20b Place of I		lame of				20c. Location -		
0 0	1 ☑ Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		,	,		,	ns 6/2	22/00 F	Aberdee	n, Ma	aryland
permit. Pag Department Important: if eny injury o once.	21. Signeture of Funerel Service Li		1111	22. Name	end Addre	ess of Facilit	у				1
Per Per Per Per Per Per Per Per Per Per	+ Kunkn Q	WILLIAMI	oshop.	Tarr	ing-(Cargo Marv	Funera	21001-	P.A.		
	23a. Part1. Enter the disease, or c shock, or heart tailure. List o	omplications that caused th	e death. Do no								Approximete Interval Between
Physician	snock, or neart tailure. List o	nry one cause on each line.									Onset and Death
/Medical	Immediate Cause (Final disease or condition resulting in death) e. Attero scleratio cardovarular disease wifu									MANUMAN	
Examiner	disease or condition resulting in death)	e. / 1 4/20 9	ue to (or as a co			0900	Two.	n org	un	10	rikuran
ē			00 (O (0) 80 8 C	nisequence (ny.						
the law requires that the open certificate be executed atternate has been signed by the attending physician end page 2 should be deteched for use as the buriel-transit completed by Physician/Medical Examiner.	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or Injury that initiated events	b	ue to (or es a co	ensequence o	of):						
physicials the burner of the burner of the burner of the burner of the burner of the burner of the the the the the the the the the the	Cause (Disease or Injury that initiated events	C	ie to (or as a co	nsequence o	(): ·						
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d by the attendeteched for us	Part II. Other significant condition	a contributing to death but	stributing to death but not resulting in the underly			rlying cause given in Part f.			23b. Did tobacco use contribute to the cause of death?		
ed by the deteched								1 🗆 Ye	2 2 No	3 Prot	bably 4 Unknown
signed be ded by P							-	24a. Was ar	autoney	24h W	ere autopsy findings
ate has been signal page 2 should be Completed								perform	ned?	co	allable prior to mpletion of cause
ate has page 2								4 🗆 V-			deeth?
	25. Was case referred to medical					00.51	/D # /0	1 □ Ye	(,	11]Yes 2□No
s certific director,	examiner?	Hospital:	2 C EB/Otr	ationt 2	DOA Ot	hor		heck only one	nca 6 DOth	ns (Connib	
£ 70	27. Manner of Death	28a. Date of Injury	28b. Ti		,	ry at			w Injury occur		Y)
fun fun	1 Natural 5 Pending 2 Accident investiga	(Month, Day')	(ear) Inj	ury M		rk?]Yes 2∐l	No				
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S afte		banding, otc.	building, efc. (Specify) City or Town, State)								
within 24 hours after death. To the Funerel Director: After completely filled in by the funer Medical Certification.	29a. Certifier 1 Certifying (Check only one)	Physician: To the best of reminer: On the basis of earth manner state	xaminetion end/	death occurre or investigeti	ed at the ti on, in my o	me, date an opinion, dee	d place, and th occurred a	due to the ca it the time, de	use(s) and me ete end placa,	anner es si and due to	teted. the ceuse(s)
within 24 hours to the Funeral I completely filled	29b. Signature and title of certifier	and manner state	· ·		29c. Licen:	se number		29	d. Date signe	d (Month.	Day, Year)
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10	20 Normand of the 1		ab //a 00-1 ==	Ame Deliah	0 2	16			41-	- (6	
10	30. Name and address of person w	no completed cause of dee	tn (Item 23e) (T	ype, Print)	900	HEET	LONA	T REDIT	ATU.	(110	21000
State	31. Dete filed (Month, Day, Year)	OOO Begistrach	Signature	0 -7	1	1	100	0	1	VVV	
State Registrar	JUN 2 0 2	UUU PROPERTIES	13	. 4	me	21					

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year **Physician** 45 A June Billy (NMN) Gerhardt II 4a Facility Name (If not institution, give street and number) 2000 29 /Medical 4b. City, Town, or Location of Death 4c. County of Death Examiner Mariner Health of Bel Air Bel Air Harford If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Jan. 21, 1941 6 Sex 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Months Days Hours Min 1√2 M 2□ F 59 Yrs. Director 216-38-4979 Maryland Usual Residence of Decadent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 7 is marked other than "natural", or items 23s or 28s-f shor traumetic event, the Medical Examinar must be notified at 1 ☐ Yes 2 ☑No Director Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3425 Tree Frog Ct. 21009 USA Funeral 12. Was Decadent Ever in U,S. Armed Forces? 1 ☐ Yes 2 D No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Ves 2 No Specify: Specify: White P 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada complated) Department of Heelth and Mentel Project of the Within 7 Department of Heelth and Mentel Projects. Important: If item 27 is marked other than "ne any injury or other traumatic event the other projects." Elementary/Secondary (0-12) Coilege (1-4or 5+) Music Owner/Operator 5+ 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maldan Surname) Be William Henry Gerhardt Marie Anna Hlavac 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Straat and Numbar or Rural Route Number, City or Town, Stata, Zip Code) Donald Brand/ Personal Rep. 1440 Stafford Rd., Darlington, MD 21034 20b. Place of Disposition (Nama of cematary, cramatory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7-3-00 Towson, Maryland 22. Name and Address of Facility ce Licensee McComas Funeral Home, P.A. Part. Emily the disease, or complications that caused the count of the mode of dying, such as cardiac of respiratory ariest, MD 21014 poproximete mock of user tailure. List only one cause on each line. Interval Between Onset and Death **Physician** Immediate Ceuse (Finel disease or condition resulting in death) Pulmonary /Medical Examiner MelliFus Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-trer Due to (or as a consequence of): phylippin Physician/Medical e to (or as a consequence of): the attending p Pert II. Other eignificent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown þ 9 24b. Were eutopsy findings eveileble prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 2 12 No 1 Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No ۲ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or Attending Physi within 24 hours after death. To the Funeral Director: After this ¢ completely filled in by the funerel dir After this 27. Manne ot Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of tnjury Certification: 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Straat and Number or Rural Routa Number, City or Town, Stata) 4 Homicide

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with the Maryland

death

filed within 72 hours efter

Baltimore, Maryland 21215-0020

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29a. Certifier

(Check only one)

29b. Signature and title of cartifier

Medical

30. Name and address of person who completed

JUN 3 0 2000

cause of death (item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32,

32 Aegistrar's Signature

2021 3 tunoster

29c. License number

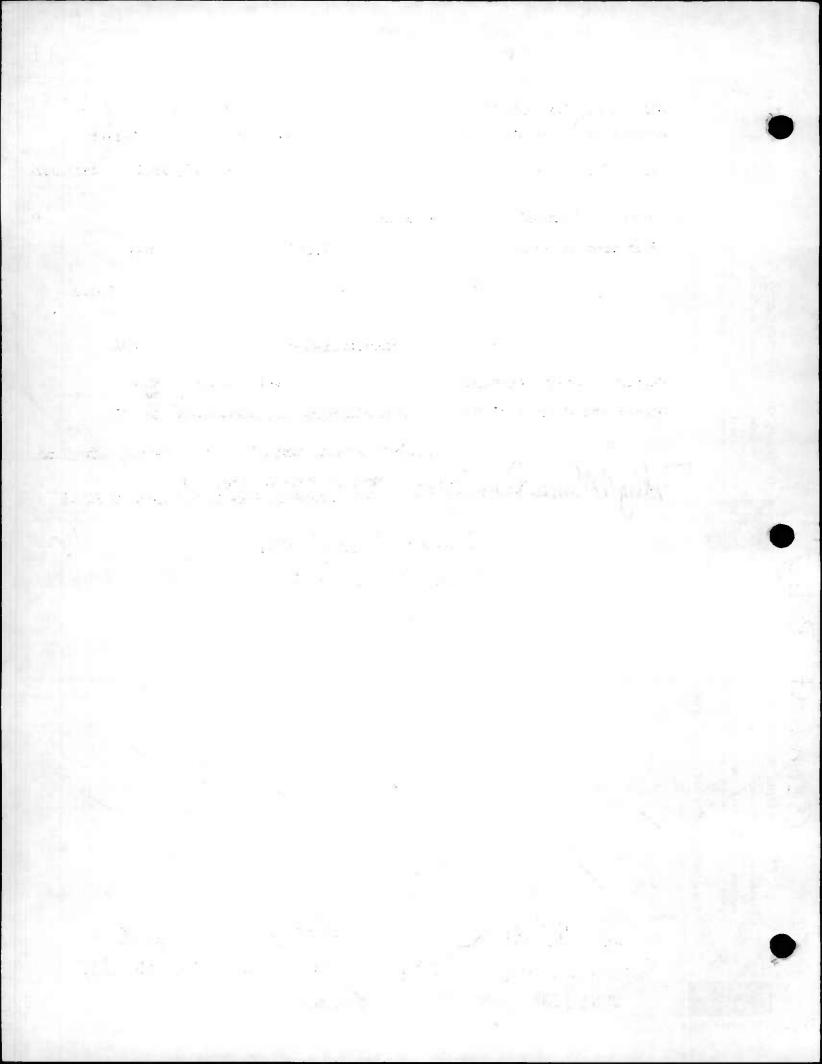
1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed, (Month, Day, Year)

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State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Dev Month **Physician** RALPH M. GIBSON JUNE 21 2000 1704 /Medical 4b. City. Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner ANNE ARUNDEL MEDICAL CENTER ANNAPOLIS ANNE ARUNDEL If Under 1 Year 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) 5. Sociel Security Number Date of Birth (Month, Dey, Year) **Funeral** Days 15 M 20 F Yrs Director 79 JULY 24 1920 MARYLAND 213-12-4876 Usuel Residence of Decedent 10c. City, Town or Location 10b. County 10d. tnside City Limits Itam 27 is marked other than "natural", or Itama 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at 1 TYYes 2 □ No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or froms 23a eny injury or other traumstic event. The Martical Emerchant Funeral 21401 13. Was Decedent of Hispanic Origin? (Specify Yes or Note the Yes, specify Cuben, Mexican, Puerto Rican, etc.) 1807 LINCOLN DRIVE 14. Race - American Indien. . Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Bleck, White, etc. 1X Yes 2 No If Yes, Give Yeer or Detes: 1953 1 ☐ Never Merried 2 X Married SpecifyBLACK 1 ☐ Yes 2 ☐ No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) Coilege (1-4or 5+) 12th TRANSPORTATION DEPT. US NAVAL ACADEMY 17. Father's Nema (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surnema) Be BERNARD GIBSON 2 MYRTLE BUTLER 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) MARJORIE Q. GIBSON (WIFE) 1807 LINCOLN DR. ANNAPOLIS, MD. 21401 20b. Plece of Disposition (Neme of cematery, crametory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition POBurlel 2 □ Cremetion 3 □ Removel from Stete MARYLAND VETERAN 6/27/00 CROWNSVILLE, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee MOOS83 22. Name and Address of Fecility WM. REESE & SONS MORTUARY, P.A. MD . 21401 Approximata Interval Between Onset and Death Larry S, Keese ST. ANNAPOLIS, such as cardiac or raspiretory errest, WEST 23e. Part 1. Enter the disease, or complications that caused the daeth. Do not a shock, or heart failure. List only one cause on each line. **Physician** /Medical tmmediete Ceuse (Final diseese or condition resulting in deeth) Examiner Examiner ed mat Or Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Couse (Diseese or injury that initiated events resulting in death) Last Due to (or es a consequenca ot): and ettending physician Physician/Medical the Due to (or as a consaquance ot): Pert It. Other atgniftcant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown ate has been signed by page 2 should be detac Completed by 24b. Were eutopsy tindings available prior to completion of ceusa of deeth? 24a. Wes en eutopsy performed? pital or Attending Physicien: The law ours after death. eral Director: After this certificate hes! filled in by the funeral director, page 2: 210 No 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical examiner? Be 26. Plece of Deeth (Check only one) 1 Yay 2 No Hospitel: Other: 4 ☐ Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) Medical Certification: To 1 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of tnjury (Month, Dey Year) 27. Mender of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Neturat 5 Pending investigation 1 TYes 2 No

The law requires that the deeth certificate be axecuted Box 68760. P.O. of Vital Records, Division To the Hospital
within 24 hours a
To the Funeral C Hospital c

with the Manyland

Maryland 21215-0020

Baltlmore,

State Registrar

DHMH 16 Rev 6/95

2 Accident

3 Suicide

29a, Certifier

4 ☐ Homicide

29b. Signature and title of certifier

6 Could not be determined

the 31. Dete tiled (Month, Dey, Year) 32. Registrer's Signeture JUN 2 7 2000

30. Name and eddress of person who completed cause of death (Item 23e) (Type, Print)

NO

1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, dete end plece, and due to the cause(s) and menner steted.

29c. License number

28t. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29d. Date/signed (Month, Dey, Year)

20

00

28a. Place of tnjury - At homa, farm, streat, factory, office building, etc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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	Certificate of Death	Reg. No.	00 66110			
	Decedent's Neme (First, Middle, Last)	2. Dete of Death Month Dey	3. Time of Death			
Physician /Medical	WILLIAM R. HENDERSON 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Li	JUNE 20 200				
Examiner	HOLY CROSS HOSPITAL SILVER SI 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs.	PRING MON	TGOMERY			
Funeral Director	Months Devs Hours Min.	8. Dete of Birth (Month, Day, Year) JAN 5 193	9. Birthplace (State or Foreign Country) MARYLAND			
4 show	10a. Stete 10b. County 10c. City, Town or Location MARYLAND PRINCE GEORGES UPPER MARLBORO		10d. Inside City Limit			
an with the marya 23s or 28s-f show ust be notified at	10e. Street and Number 10f. Zip Code	10g. Citizer	of Whei Country?			
or items	12408 STURDEE DRIVE 11. Meritel Stetus 1 Never Merried 2 Merried 3 Widowed 4 Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 Never Merried 2 Merried 3 Widowed 4 Divorced 1 Never Merried 2 Merried 1 Yes, Specify Cuban, Mexican, Puerto ff Yes, Specify: 1 Yes, Give 1953-56	pecify Yes or No- Prican, etc.)	USA Rece - American Indian, Black, White, etc.			
"natural".	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work		of Business/Industry			
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d out		e (First, Middle, Maiden Su JONES	meme)			
th and	19e. Informent's Neme/Reletionship (Type, Print) WILLIAM R. HENDERSON JR. (SON) 12408 STURDEE					
H F F	20a. Method of Disposition POBurial 2 Cremetion 3 Removel from Stete 4 Conetion 5 Other (Specify) 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) HILL CREST CEMETERY 6	Date 20c. Local	APOLITS, MD.			
Department important: If any injury or once.	21. Signeture of Funeral Service Licensee MOOY83 22. Name and Address of Facility					
	Zavy S. Reese 821 WEST ST. ANN 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac	APOLIS, MD	21401 Approximete			
hysician /Medical Examiner	shock, or heert failure. List only one ceuse on each line. Immediate Cause (Finel disease or condition resulting In death) MASSIVE HEPATIC FAILURE resulting In death)		Intervet Between Onset end Death 7 days			
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s certificate director, pag	examiner?	th (Check only one)				
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Please Type or Print in Black Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death **Physician** Month Year Raymond Joseph Hoerl 21, June 2000 9:00 am /Medical 4a Facility Name (If not institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 115 Roosevelt Avenue Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) OCT 16, 1925 Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1 □XM 2 □ F 74 Vrs Director 219-18-1698 Maryland Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Anne Arundel Glen Burnie 1 TYAS 217 No Director 289-0 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 115 Roosevelt Avenue 21061 Funeral IISA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Yeer or Detes: WWII 11 Marital Status Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. fied within 72 hours after 1 ☐ Never Merried 2 ☐ Merried 3altimore, Maryland 21215-0020 ò 1 ☐ Yes 2 X No Specify Specify: White à 3 ☐Widowed 4 □ Divorced WWII Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Sugar Elementary/Secondery (0-12) College (1-4or 5+) Manufacturing Foreman 10 permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyp Important: if Nem 27 is marked other any Injury or other trauments. 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Charles J. Hoerl Mary Virginia Carson 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 3501 Cokesbury Court, Pasadena, MD 21122

Boto Disposition (Name of Date 200. Location - City or Town, Stete James McDermott/ friend 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition June 27 1 Burlel 2 □ Cremetion 3 □ Removel from State Glen Burnie, MD Glen Haven Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Egneral Service Dipenses 22. Name and Address of Fecility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 The Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deetl Physician **e** ancer of Common R. Le Doct Immediete Cause (Finel diseese or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunta-transit completely filled in by the funeral director, page 2 should be detached for use as the bunta-transit Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Diseese or Injury that initiated events resulting in death) Last Due to (or es e consequence of): P.O. Box 68760, Due to (or es a consequence of) Pert If. Other algrificant conditions contributing to death but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Records, Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Wes an autopsy 2E No 1 ☐ Yes 2 ☐ No 1 Yes of Vital 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Menner of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation t []Natoral 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Cortifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated.

State Registrar

31. Defe filed (Month, Day, Year) **JUN 2 7** 2000

29b. Signefure and title of certifier

32. Registrer's Signeture

30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print)

Robest

29c. License number

29d. Date signed (Month, Day, Year)

MD

Kroegnick

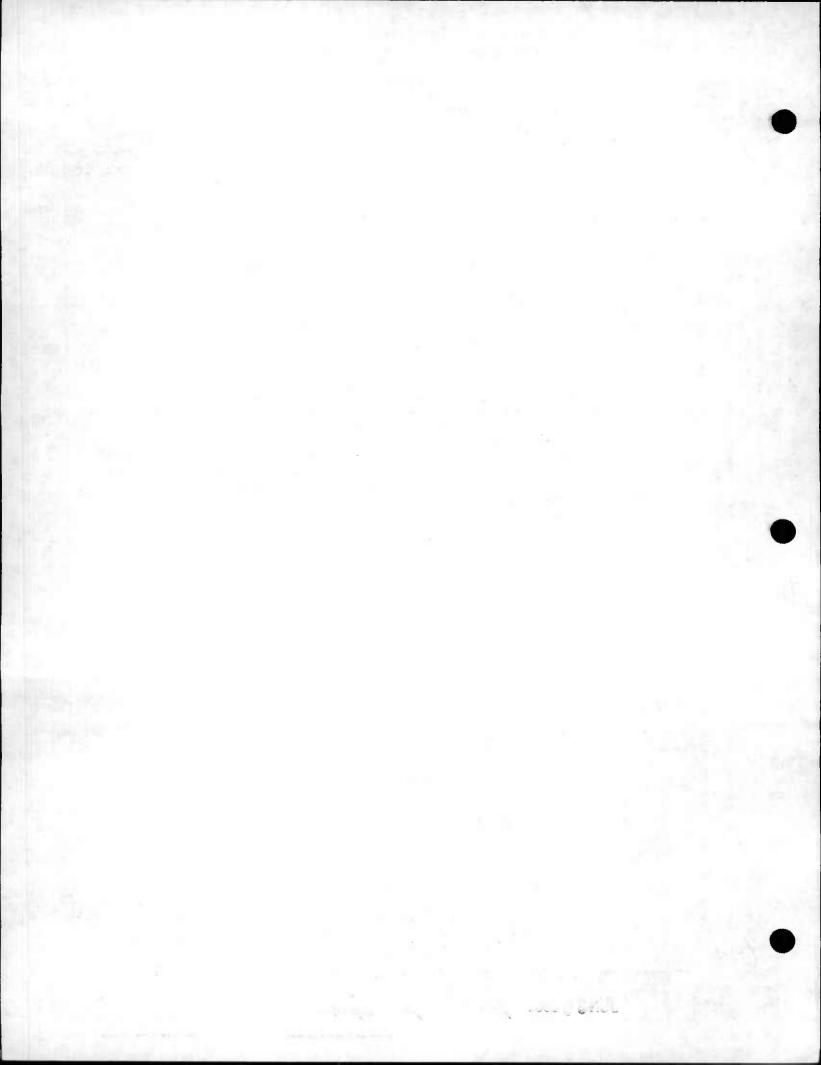
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Year 2000 Dey 27 **Physician** 10:15 am June Robert Phillip James, Sr. /Medical 4c. County of Death 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner VA MEDICAL CENTER FORT HOWARD, MARYLAND FORT HOWARD BALTIMORE 7. Age (In yrs. last birthdey) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months Days Hours 12 M 2□ F 271-32-2183 60 Virginia Director West Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla 1 Yes 2 XNo Directo Edgewood Herrie 23a or 25a-f Maryland Harford event, the Medical Examiner must be notifi-10g. Citizen of What Country? 10e. Street and Number 10f Zip Code 736 Sequoia Drive Funeral 21040 USA 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Black, White, etc. 11. Marital Status NO Yes 2 No If Yes, Give Year or Detes:1958-60 hours after 1 Never Married 2 Married ò altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filled within 72 and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Auto Mechanic Engine Repair Shop 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be permit. Pages 1 and 2 should be Department of Health and Mental reportant: if Item 27 is marked or Frank Stanley James Priscilla Martha Straub 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) RORERT Ann Veronica James/ Wife 736 Sequoia Drive, Edgewood, Maryland 21040 20b. Plece of Disposition (Name of cemetery, crematory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete Date 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from Stete 4 ☐ Donation 5 ☐ Other (Specify) 6-30-00 Towson, Maryland Hillton Service Corp. 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 1317 Cokesbury Road, Abingdon, MD 21009 Pert1. Enter the disease, or compshock, or heart tailure. List only blus tons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximete Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Lung Cancer with Metastasis one year disease or condition resulting in deeth) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificata be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest burial-tran Due to (or as e consequenca of) physician the burial Box 68760 Physician/Medical Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 No 2 No 3 Probably 4 Unknown Coronary Artery Disease of Vital Records. þ 24b. Were eutopsy findings evalleble prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed Chronic Obsrtructive Pulmonary Disease page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 No certificate Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1₺ Inpatient 2□ ER/Outpetient 3□ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To this funeral 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred Affer Division or Attending 1 Neture 5 Pending investigation burs after death. 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Sulcide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral E completaly filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) and manner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end pleca, and due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29d. Dete signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number June 27, 2000 UN 30. Neme and eddress of person who completed cause of death (Item 23a) (Type, Print) Aurora Tan, M.D. 9600 North Point Road, Fort Howard, Maryland 21052 31. Date filed (Month, Dey, Year) 32. Registrer's Signature State JUN 3 0 2000 outes Registrar

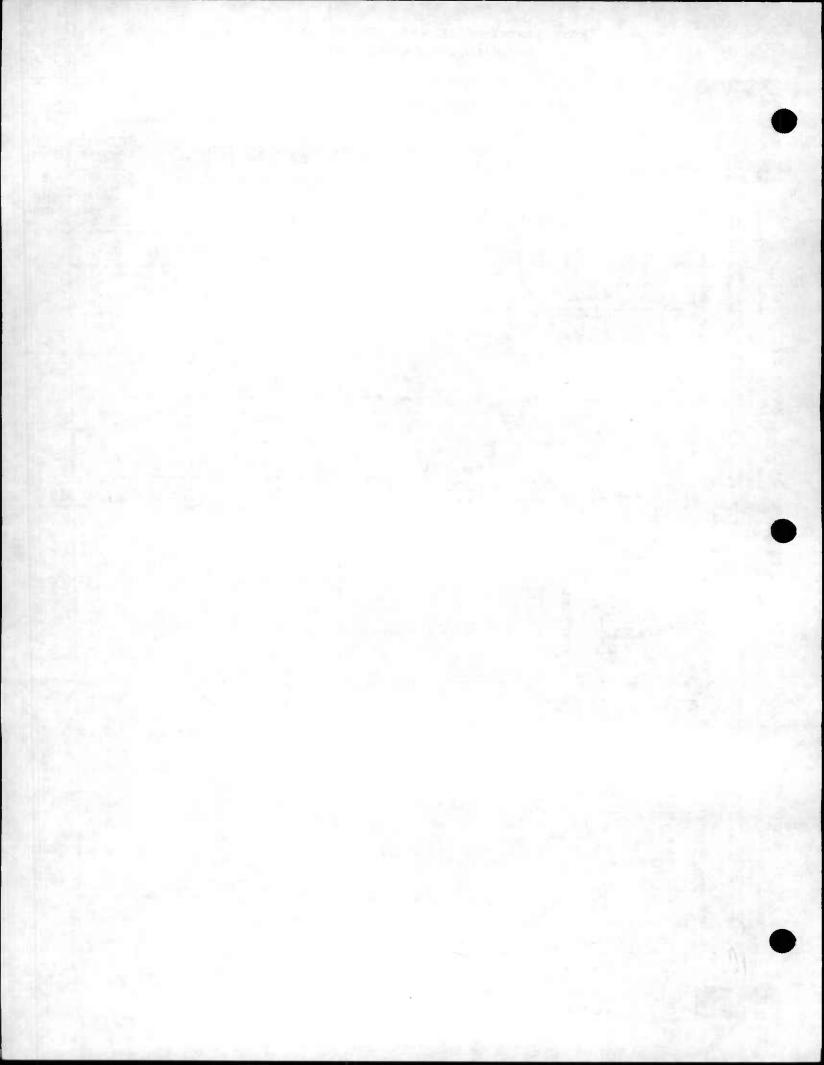
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State of Maryland / Department of Health and Mental Hygiene 0 2 2 1 1 6

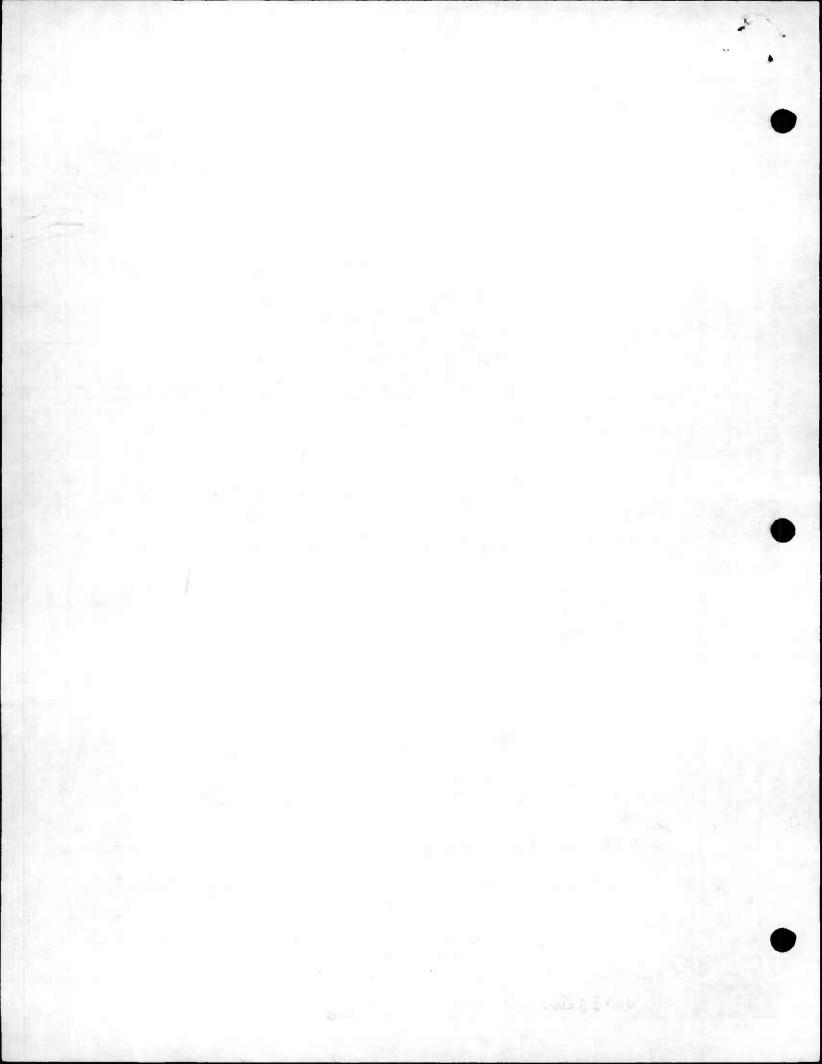
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amend Item#16b HCHD 7/6/00 brh 2. Date of Death 1. Decedent's Nama (First, Middle, Last) 3 Time of Death **Physician** 2000 3:15 am Richard June. 100 /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner 611 Sandray Terrace Bel Air Harkord 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. 8. Date of Birth (Month, Pay, Year) May 11, 1952 6 Sex 7. Age (In vrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1♥M 2□F Months Hours 48 Yrs. Maryland 215-56-4963 Director Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10a. Stata 10c. City. Town or Location 10d. Insida City Limits ahow 1 ☐ Yas 2 👿 No Funeral Director Maryland Harford Bel Air 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 611 Sandray Terrace 21015 U.S.A. 238 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 (X) No If Yes, Giva or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married 21215-0020 1 Yas 2 No Specify: specify: White p 3 ☐ Widowed 4 ☐ Divorced Veer or Dates Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Baltimore County
Police
Baltimore City Pol mentary/Secondary (0-12) College (1-4or 5+) 12th grade Police Officer i. Peges 1 and 2 should be filed w tmant of Health and Mental Hygier tant: If Item 27 Is marked other th jury or other treumatic event, the Baltimore, Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Melvin M. Kram Mary E. Gourley 19e. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Nanette M. Gebhardt-Kram (Wife) 611 Sandray Terrace. Bel Air, MD 20b. Place of Disposition (Name of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata Department of H Important: If Her eny Injury or oth pace. 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Joseph Church Cem. 17/1/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Addrass of Facility Schimunek Funeral Home of Bel Air, 610 W. MacPhail Road, Bel Air, MD 21014 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Finel diseasa or condition resulting in death) . Transitional Cell Carcinoma of Urinary Bladder /Medical Years Examiner metastatic to liver Physician/Medical Examiner 6mos The law requires that the deeth cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, the Dua to (or as a consequence of): 20 esn Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? sate hes been signed by page 2 should be datac 3 Probably 4 Unknown 1 ☐ Yee 2 ☐ No à 24b. Wara autopsy findings available prior to Be Completed 24a. Was an autopsy performed? complation of causa of death? 22 No cartificate 1 Yes 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: 25. Was casa referred to medical 26. Place of Deeth (Check only ona) Hospital: 1 | Inpetient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yas 2 No this 27. Manner of Death 28a. Deta of Injury (Month, Day Year) 28b Time of 28d. Describe how Injury occurred 28c. Injury af Work? After 5 Pending invastigation Naturel after death. 1 Yes 2 No 2 Accident tha 6 Could not be detarmined ie Hospital or Attern 24 hours after dar Ne Funerel Directo pletaly filled in by th 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 - Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completaly fi (Check only one) 29b. Signature and title of certifig 29c. License number 29d, Date signed (Month, Dey, Year) 2000 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Wolfe Str Balhmore 32. Registrar's Signatura Month, Day, Year)
JUN 3 0 2000 State Registrar

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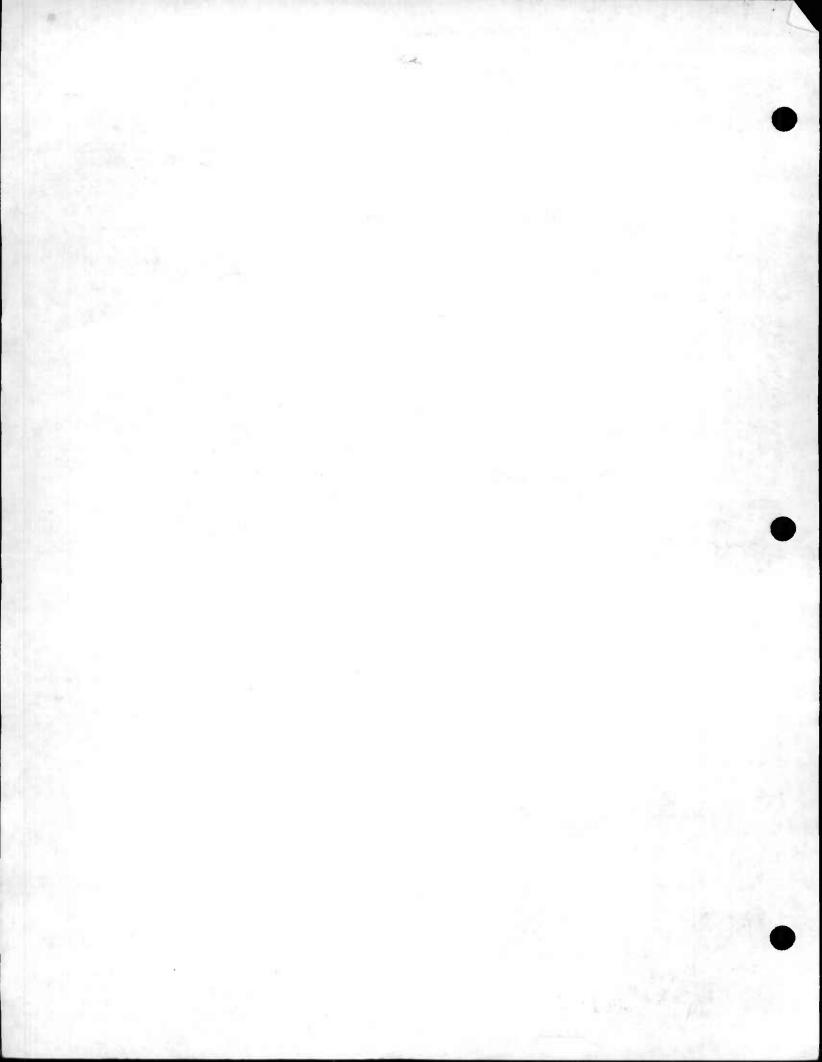
July 10, 2000 O.C.M.E. Neme end address of person who completed cause of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201 Chutem lenmes

State Registrar

31. Date filed (Month, Day, Year) JUL 12

32. Registrer's Signeture

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day 22 Month **Physician** June 2000 8:55 PM Adolph Klimes /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel 6. Sex 1 M 2 □ F If Lindar 1 Yaar 8. Data of Birth (Month, Dey, Year) May 1, 1912 5. Social Security Number If Undar 24 Hrs. 7. Aga (In yrs. last birthday) Birthplece (Stata or Foraign Country) **Funeral** Months Hours Days Yrs 88 Director 216-05-3207 Maryland Usual Rasidence of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow item 27 is marked other than "natural", or items 23a or 28a-f abov other traumstic event, the Medical Examinal must be notified at 1 ☐ Yas 2 ☐ No Director MD Anne Arundel Annapolis 10e Street and Number 10f Zin Code 10g Citizan of What Country? 21403 757 USA Warren Drive Funeral 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedant Evar In U.S. Armed Forcas? Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after 1 □Was 2 □ No If Yes, Giva Yeer or Detas:1940 – 59 1 Navar Married 2 Married altimore, Maryland 21215-0020 1 Yas 2√ No Specify: Specify: White g 3 Widowed 4 □ Divorced Completed 15. Decedant's Education (Specify only highast grada complated) 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use ratired) 16b. Kind of Businass/Industry Hygiene. Elemantary/Secondary (0-12) Cotlega (1-4or 5+) Proprietor Convenience store 12 permit. Pegas 1 and 2 should be filed:
Department of Health end Mental Hygid
Important: If item 27 is marked other I
any Injury or other traumatic event, III 17. Fathar's Nema (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be Rose Krystov Anton Klimes 0 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stata, Zip Coda) 707 Oser Drive Crownsville, MD 21032 Robert F. Klimes / son 20a. Method of Disposition 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20c. Location - City or Town, Stata Date 1 XBurial 2 ☐ Cramation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Hillcrest Mem. Gardens 6+26-00 Annapolis, MD. 22. Nama and Addrass of FacilityJohn M. Taylor Funeral Home, Inc. 21. Signatura of Funaral Sarvice License 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata Intervat Batween Onsat and Daath **Physician** /Medical immediate Ceuse (Final wk disaasa or condition resulting in death) Examiner Examiner burial-transit Sequantially list conditions, if any, laading to immadiata ceusa. Entar Undarlying Ceusa (Diseasa or Injury finat initiated avants resulting In death) Last Dua to (or as a consequence of): **Bud** physician es the burial-Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.0. 23b. Did tobacco use contribute to the cause of death? lun 1 Yss 2 No 3 Probably 4 Unknown Division of Vital Records. by 24b. Wara autopsy findings availabla prior to complation of causa of death? 24a. Was an autopsy performed? Completed has 2 X No 1 Yas 1 Yas 2 No 25. Was casa refarred to medicat axaminar? Be 26. Place of Daath (Check only one) Hospital: Inpatiant 2 ER/Outpatient 3 DOA Othar: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas No 2 this 28a. Data of tnjury (Month, Dey Year) 28d. Dascribe how injury occurred Certification: 27. Manner of Death 28b. Tima of 28c. Injury at Work? To the Hospital or Attending P within 24 hours after death.
To the Funerel Director: After t Natural 5 Panding invastigation 1 Yes 2 No 2 Accidant 6 Could not be detarmined 28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida Plece of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) filled in by 4 ☐ Homicida Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) end manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, dete end plece, and due to the ceuse(s) and manner stated. edical 29a. Certifian completaly (Check only 29c. Licansa number 29b. Signature and Ittle of certifie 29d. Date signed (Month, Day, Year) D38118 00 30. Nama and addrass of person who complated causa of death (Itam 23a) (Type, Print) Parkry Stite 100 2003 MD Medicul 31. Dafa filad (Month, Day, Year) 32. Pegisfrar's Signafura State **JUN 27** 2000 Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22120. Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Data of Death 3. Time of Deeth Dey H MONGOLD LEONARD JUNE 26 13:13 2000 4a. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth RANDALLSTONN HOSPITAL BACTIMORE. NORTHWEST 7. Aga (In yrs. lest birthday) If Undar 1 Year If Undar 24 Hrs. Months Deys Hours Min. 5. Social Sacurity Number 8. Dete of Birth (Month, Dey, Year) Aug. 15, 1906 Birthplace (Steta or Foreign Country) Deys 1 M 2□ F Yrs. 213-01-0611 Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland N/A Baltimore 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21213 U. S. A. 3812 Lyndale Avenue 12. Wes Decedent Ever in U.S. 12. Armed Forces? 1 1 Yes 2 □ No 11 Yes, Give Year or Dates: 1942 – 1945 11. Marital Status Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: 3 ☑ Widowed 4 □ Divorced Specify: White 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A Machinist Crown Cork & Seal 17. Fethar's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Adam M. Mongold Mary E. Holsinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Arthur L. Drager, Atty. Light Street, Suite 510, Baltimore, Md. 21202 20a. Method of Disposition 20b. Place of Disposition (Neme of cemetery, cremetory or other piece) Date 20c. Locetion - City or Town, Stete W Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Gardens of Faith 6/29/00 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home Inc. Mark 3331 Brehms Lane, Baltimore, Maryland 21213 23a. Pert1. Enter the disease, or conshock, or heart failure. List only complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete Interval Between Onset end Death Immediate Cause (Finel disease or condition resulting in death) . SEVERE GASTRO INTESTINAL BLEEDING. Due to (or es e consequence of): Due to (or es e consequence of): Due to (or as a consequence of) Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the ceuse of deeth? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Wara autopsy findings available prior to completion of ceuse of deeth? 24a. Wes en eutopsy parformed?

Physician /Medical Examiner

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7 is marked other than "natural", or items 23a or 28a-f shov treumatic event, the Modical Examiner must be notified at

permit. Pages 1 and 2 should be filed withit
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than
any injury or other treumatic access.

the Maryland

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Sequentially list conditions, if eny, leeding to immediate ceuse. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in deeth) Lest by

CARDIOMYOPATHY

ARTERIOSCLEROSIS. 25. Was cese referred to medical examiner? 26. Piece of Death (Check only one)

2 No 1 ☐ Yes 2 ☐ No

1 Yes 2 No 27. Menner of Deeth 1 Natural 2 Accident 3 ☐ Suicide

4 Homicide

5 Pending investigation 6 Could not be

Hospitel: 1 Inpatient 2 ER/Outpetiant 3 DOA 28a. Dete of Injury (Month, Day Year) 28b. Time of

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28c. Injury et Work? 1 Yes 2 No

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred

28f. Location (Street end Number or Rurel Route Number, City or Town, State)

29a, Certifier (Check only one) 1 Certifying Phyelclen: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the bests of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner stated.

29b. Signature and the of certific 30. Name and address of purson who completed cause of death (Item 23a) (Type, Print) NORTHWEST HIS PITAL

29c. License number D42723.

29d. Date signed (Month, Dey, Yeer) JUNE 26TH

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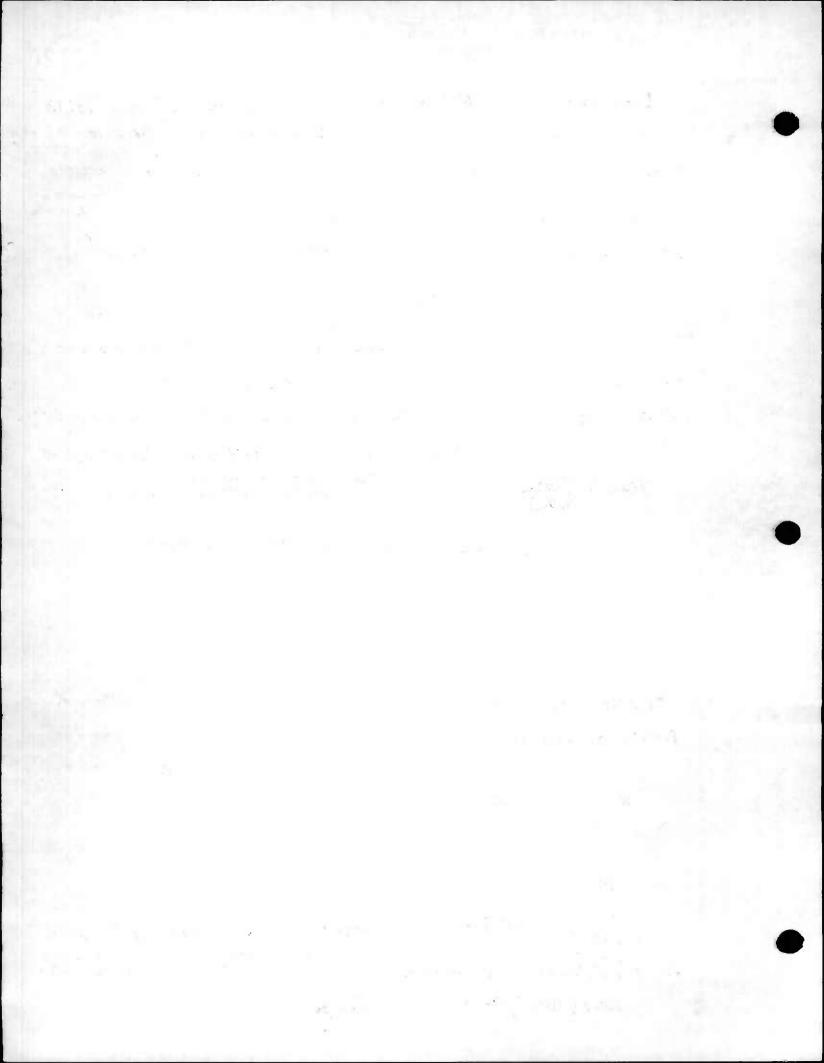
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Month **Physician** JUNE 22 2000 2:25 am LOUIS McGOWAN III /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCREST HOSPICE CENTER If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Funeral Days 1 1 M 2 □ F Director 18 1939 MARYLAND 219-26-2906 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County 1 X Yea 2 ☐ No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21403 USA Funeral 20 ALDER ROAD 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Maritel Stetus 1 Yes XXNo If Yes, Give Year or Dates: hours after 1 Never Married 2 Merried 8 21215-0020 1 Yes 2 No Specify: Àq Specify BLACK 3 Widowed Woivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) 0 PLUMMER US NAVAL ACADEMY 11th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be Pages 1 and 2 should be nent of Health and Mental HILDA JASON LOUIS McGOWAN JR. 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Relationship (Type, Print) nt of Health a : If Nem 27 la 20 ALDER RD. ANNAPOLIS, MD. 21403 MARTINI BEAN (SISTER) altimore, 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition NDBurlet 2 Cremation 3 Removal from State Department of Important: If ANNAPOLIS MEM. GARDENS 6/27/00 ANNAPOLIS, MD. 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MOO 483 22. Neme and Address of Facility WM. REESE & SONS MORTUARY, P.A. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or respiratory arrest, Annual or resp Approximete Intervel Between Onset and Death **Physician** tmmediete Cause (Finat disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence ot): The law requires that the death certificate be that initiated events resulting in death) Last Due to (or as a consequence ot): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings aveilable prior to completion of ceuse of death? 24a. Was an autopsy performed? Completed page 2 should 1 Yes 1 ☐ Yes 2 ☐ No of Vital Physician: 25. Wes cese reterred to medicet examiner? funeral director. edical Certification: To Be 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how tnjury occurred Division or Attending Netural 2 Accident 5 Pending investigation after death. 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely To the 29c. License number 29d. Dete signed (Month, Dev. Year) 29b. Signature and title no 30. Name and address of person who completed cause of death (Her h 23a) (Type, Print) 21204 31. Dete tiled (Month, Day, Year) Registrer's Signature State JUN 2 7 2000 Registrar

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Nama (First, Middle, Last) 3. Time of Death Month **Physician** RUTH MELVIN 02:41 00 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 19, 1920 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1□M 2以F Yrs. 80 Georgia 256-24-9667 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f show 1 X Yes 2 ☐ No Director Florida Sarasota Sarasota 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 3014 Regatta Drive 34231 USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes ≥ 20 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Sfatus 14. Race - Amarican Indian. Black, White, etc. pemilt. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If fem 27 is marked other than "natural", or fiel monthly of other transmitted event, the Medical Earth any Injury or other transmits. 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Tes a No Specify: Specify: by 3 Widowed 4 □ Divorced White Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) Be John William Buchan Lizzie Solomon 10 19a. Informant's Name/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sharon Kay Chappell/ Daughter 1203 John Ross Court Crownsville, Md. 21032 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 06-25-00 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Cemetery Fitzgerald, Georgia 21. Signature of Funeral Service Licanses 22. Name and Address of Facility John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester Street Annapolis, Maryland 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Daath **Physician** Congestive Heart Failure Immediate Cause (Final disease or condition resulting In death) Tyeur /Medical Examiner Due to (or as a consequenca of): Severe Lacric Acidosis Examiner 24hr The law requires that the death cartificate be executed and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequenca of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by the 1 Yes 2 No 3 Probably Unknown Division of Vital Records. by 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No Certification: To 12 Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this 28e. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: After completaly filled in by the fun 1 Yas 2 No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and pleca, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certified 29c. Licensa number 29d. Date signed (Month, Day, Year) 6-23-00 D24804 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Annopoles med

State Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

00 2212

			Cer	tificate of	Death		Reg. No.		
ų .	1. Decedent's Name (First, Middle, Last	1)		10 10 11		2. Dete of D			3. Time of Death
Physician	Rebecca E	lizabeth	McKown			June	21 20	Year	11:47 PM
/Medical	4e Facility Name (If not institution, give	street and number)			4b. City, Town, or				
Examiner					A	•			
	48 Lawrence Ave. 5. Sociel Security Number 6. Se		last histhday)	If Under 1 Year	Annapol:	S O Date of B	rth	Aru	
Funeral	11	7. Age (In yrs.	Yrs.	Months Days	Hours Mir		ey. Year)	Cour	place (Stete or Foreign ntry) sylvania
Director	163-46-2261	47	110.			Julie /	, 1933	renns	sylvania
2 .	Usual Residence of Decedent 10a. Stete 10b. County	10c Cit	v. Town or Loc	ration				1	IOd. Inside City Limits
aye of a									1 ☐ Yes 2 ☐ No
oct Me s	MD Anne Aru	ndel An	napolis						
or 28a-f show be notified at Director	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Coun	ntry?
23 th	48 Lawrence Ave.			2140)3	9-	US	A	
of the death of the thems 23 diner must Funeral	11. Meritel Status	12. Wes Decedent Ever in U Armed Forces?	,S. 13. W	Vas Decedent of I Yes, specify Cub	Hispenic Origin? (Specify Yes or N	0- 14. Rac	ce - Americ	
이 후 보면 교	1 ☐ Never Married 2 ☐ Merried	1 Yes 20 No		☐ Yes 2 No					•
21215-0020 d within 72 hours after death with the Maryla glene. r than "natural", or larns 23e or 23e-f show than "natural", or larns 23e or 23e-f show than "natural", or larns and proceed as more perfectly completed by Funeral Director		If Yes, Give Year or Dates:		LI Tes ZIZMNO	Specify.		Specify	Wh:	ite
I 21215-0 ad within 72 ho sypiene. ser then "natur it, the Medical."	15. Decedent's Edu	ucetion	16a. Deced	ent's Usual Occup kind of work done	pation	and in a	16b. Kind of B	usiness/Inc	dustry
21 21 21 21 21 21	(Specify only highest grad	College (1-4or 5+)	life. D	O NOT use retire	d)	orking			
Paris Po	Elementary/Secondary (5 12)	2	Vice	Preside	ent		Bankin	ng	
D STATE O	17. Father's Name (First, Middle, Last)	STATE AND			18. Mother's No	eme (First, Middle	e, Meiden Sumen	ne)	
yland build be fi Mental H Mental H artic ever To Be	John Olynik				Vereni	ca Varad	:		
T MAN P	19a. Informant's Name/Relationship (T	vne Print)	19h Mallin	g Address (Street				State Zin	Code)
Maryland d 2 should be file fifth and Mental Hy T's marked other traumatic event									, 0000)
E = 14 P		usband		wrence A		napolis,	MD. 21	.403	oue State
Pages vent of h	20a. Method of Disposition 1 Burlal 2 Cremetion 3 Di	Removet from Stete	cemetery, crem	sition (Neme of natory or other ple	ice)	Date	20c. Location -	City of 10	JWII, State
Pag mit: ury our	4 ☐ Donation 5 ☐ Other (Specify,	St	. Demet	rios Cen	netery	5-24-00	Annapol	is, h	MD
Baltimore, semit. Pages 1 s bepartment of Hea mportant: if Item my Injury or othe side.	21. Signature of Funeral Service Licens	see O	22.	Name end Addre	ess of Facility Jo	ohn M. T	aylor Fu	nera!	1 Home, Inc.
m #8228	PR	Konnell		7 Duke o					
	23a Pert1. Enter the disease or comp	lications that caused the deat						115,1	Approximete
	23a. Pert1. Enter the disease, or comp shock, or heart failure. List only of	one cause on each line.	50 1101 01110	, , , , , , , , , , , , , , , , , , , ,				1	Interval Between Onset end Death
Physician	Immediate Cause (Finat	0111	2	11	1+1	44			2
Examiner	disease or condition resulting in death)	a /7/10/0/85/	once	Mull	titors	me	VA I	- 10	Lynn
HEAT COLOR		Due to (c	or as a conseq	uence ot):					/
oxecuted in and intransit		h							
X 68760, certificate be executed ding physician and se as the burial-transit	Sequentially list conditions,	Due to (c	or as a consequ	uence of):		16/-1111			
e ex orial	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury								
ostificate be eding physician se as the burian	thal initiated events resulting in death) Last								
68 iffica g ph as t as t	resulting in death) Last								
ocarding use a use a		d						1	
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P.O. nat the de de by the detached Physic	Part II. Other significant conditions co	intributing to death but not res		23b. Did tobacco use contribute to the cause of dear					
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0 8 5 B								T nah M	ere autopsy findings
The law requires tate hes been sign page 2 should be Completed by							s en eutopsy formed?	av	ailable prior to
Recorded to the second to the								of	mpletion of cause death?
The I						10	Yes 2 No	1[☐Yes 2☐ No
f Vital Re yelclen: The Le s certificate he director, page	25. Wes case referred to medicet				26. Place of D	eath (Check only	one)		
of Vita Physician: rithis certific ral director,	exeminer?	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatien	t 3 DOA Ot	hae	1/	sidence 6 Oth	per (Specii	(h/)
Phys Phys raidi di	27. Menner of Deeth	28a. Date of Injury	28b. Time of				how injury occur		.77
On On Aller funer funer	1 Natural 5 Pending	(Month, Day Year)	Injury	M 1	ork?]Yes 2∐No				
Division of the or Attending P as a the deeth. In Director: After the in by the funer Certification:	2 Accident Investigation 3 Suicide 6 Could not be	200 Diago of Injury At h	ama farm atre			29f Location	(Street and Numi	her or Run	al Poute Number
or A parties in by	4 Homicide determined	28e. Place of Injury - At h building, etc. (Specil	by)	et, factory, office			own, State)	Jer or ridie	ar riodie ridinber,
Division o To the Hospital or Attending Ph within 24 hours after deeth. To the Funeral Director: After thi completely filled in by the funeral Medical Certification:	- V								
Cal	(Check only Q Medical Exam)	reiclan. To the best of my kno Iner: On the basis of examine	wledge, deeth	occurred et the ti	ime, date and ple- opinion, death oc	ce, and due to the curred at the time	e cause(s) and ma b. date and place.	anner as s	steted. to the cause(s)
To the Hospital Within 24 hours. To the Funeral completely filled Medical Co	1	end manner stated.							
N To To	29b Signature and title of certifier		7	29c. Licen	se number	C.	29d. Date signe		1
	- lon//X	eller M		1)	1852	7	06.3	22 -	290
	30. Name and address of person who o	completed ceuse of death (Iter	n 23a) (Type I	Print)					
	1.	2007 Tidewater C			d 21701				
State	31, Date filed (Month, Day, Year)	32. Registrar's Signa	CVALUE OF THE PARTY.	Aportis, M	u, 21401				
State	MMI & 87 000	no Same	A	Asser	Sal.				

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'e Neme (First, Middle, Last) 2. Dete of Death Month O'Connor 25 Z000 **Physician** Lillian 03:25A 06 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday).

8 4 Yrs. 8. Date of Birth (Month, Day, Year) 07-10-15 5. Sociel Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1□M 20 F 213-03-630 2 Director Maryland Usuet Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom Annapolis Anne Arundel 1 ☐ Yes 2 XNo Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Examiner must be r 21401 130 Hearne Road USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. pemit. Pages 1 and 2 should be filed within 72 hours after a Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural, or item any injury or other traumatic avent, me Medical Exercises pages. 1 ☐ Never Merried 2 ☐ Merried 1 Yes 2 No If Yes, Give Year or Detes: 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 □ Widowed 4 □ Divorced Completed Decedent's Usuel Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Cotlege (1-4or 5+) Homemaker 12 Home aftimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Florence Briggs Ferdinand Smith 19a. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2967 Mallview Road, Baltimore, MD Ronald Saunders/ son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) Date 20c. Location - City or Town, Stete June 27 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removet from Sal 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD Metro Crematory 2000 21. Signature of Funeral 26 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 enter the mode of dying, such as cardiac or respiratory errest, Approximate tntervel Between Onset and Death **Physician** /Medical Cardiomyopath Examiner Examiner hysician and the burial-transit or Attending Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Atheroscleronz Cordiovascular Division of Vital Records, P.O. Box 68760, Physician/Medical Diabetes Mellitus signed by the attending p Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypercholesterolemia Completed by 24b. Were autopsy findings evailable prior to completion of cause of death? 24a. Was an eutopsy performed? 2 No 1 ☐ Yes 2 ☐ No certificate 1 ☐ Yes 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Ves 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manper of Death funeral 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred After 1 Natural 5 Pending investigation s after death.

I Director: After the by the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnishment of the furnis 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Plece of Injury - At home, ferm, street, lectory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29a. Certifier completely (Check only one)

State Registrar

DHMH 16 Rev 6/95

JUN 2 7 2000

29b. Signature end title of certifier

31. Date liled (Month, Day, Year)

Salvatore

aura 32 Registrer's Signature

Muno

30. Nama and address of person who completed cause of death (ttem 23a) (Type, Print)

5.

2003 Medical Parkway Suite 100, Annapolis mo

29c. License number

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29d. Date signed (Month, Day, Year)

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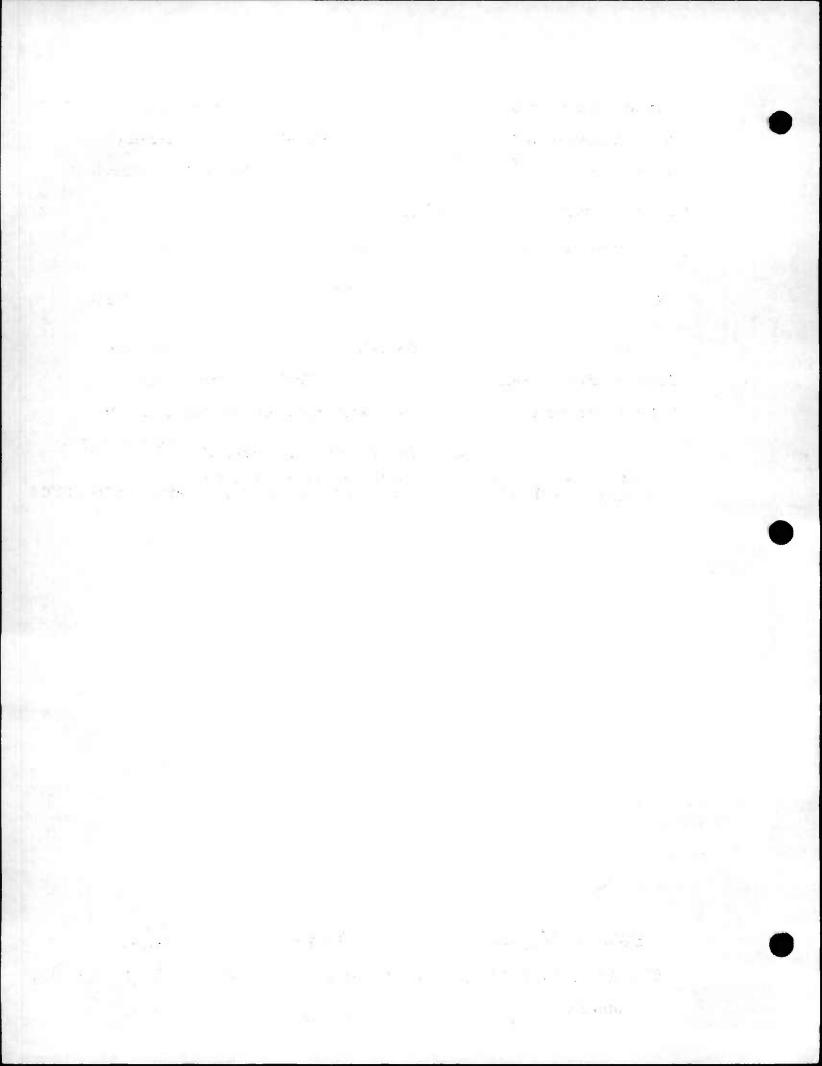
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JUN 2 9 2000 James J. Herid

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/Medic		Audrey Ev	ans 1	Price						June :	25,	2000	1451	7:35 PM		
Examin		4a. Facility Nama (If not Ins			ber)				4b. City, Town, or I		-	4c. County	of Death			
	-	956 F. Hills	boow	Road				1	Bel Air			Harfo	ord			
Funeral		5. Social Security Number	6. Sa			. lest birthday)	If Undar	1 Yaar	if Undar 24 Hrs.	8. Data of I	Birth			ce (State or Foreign		
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 27 Day 5:00 A.M. JUNE 2000 NAOMI MAY POOLE 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death FOREST HILL MARINER HEALTH OF FOREST HILL HARFORD If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Days 1 M 20 F Yes 215-18-1937 78 May 23, 1922 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 25 No Maryland Harford Forest Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 109 Forest Valley Dr. 21050 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yea ⊉ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 ☐ Married 1 Yes 20XNo Specify: Specify: White 3 ☐ Widowed 4 St Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16h Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Thomas Neidlein Della Rebecca Burkentine 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanne M. Poole - Daughter 7358 Broken Staff, Columbia, Maryland 21045 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Angel Hill Cemetery 6/29/00 Havre de Grace, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part I. Enter on disease, or complications that caused the chain. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear initure. List only one cause on each line. 1317 Cokesbury Road, Abingdon, Maryland Approximate tnterval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a con Willence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 200 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral

Director

28a-f show must be notified at

Norma 23a

permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haelih and Mental Hyglene. Important: if item 27 le marked other than "natural", or iten any Injury or other traumatic event, the Medical Evantural once.

Baltlmore, Maryland 21215-0020

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Medical

State Registrar

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29b. Signature and tille of contille

Manner of Death

Natural

2 Accident 3 Suicide

4 ☐ Homicide

29a. Certifier (Check only one) 5 Pending investigation

6 Could not be

28a. Date of Injury (Month, Day Year)

🔁 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated.

28c. Injury at Work?

1 Yes 2 No

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date pigeed (Month, Day, Year)

Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

Pa Signa

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

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Please Type or Print in Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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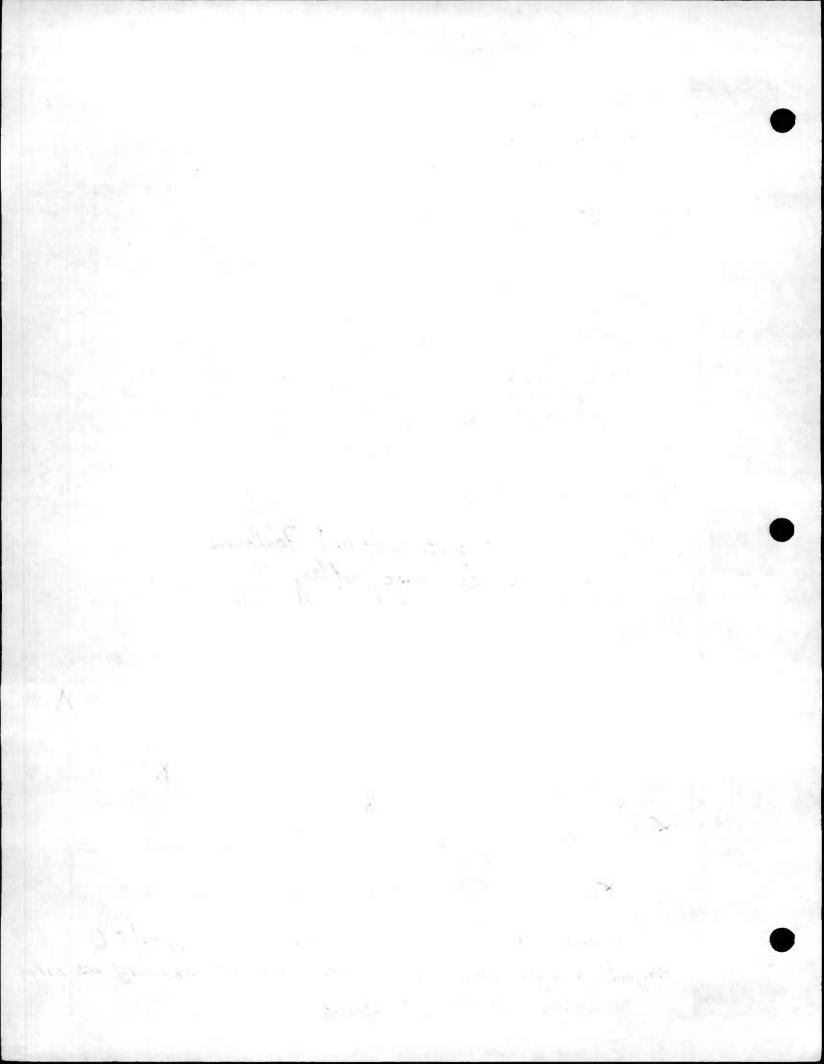
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth Month 3. Time of Death Year **Physician** John Clifford Postley, Jr. 4b. City, Town, or Location of Death 4c. County of Death 0006 /Medical 4a Facility Name (If not institution, give street and number) Examiner SALISBURY WICOMICO PENINSULA REGIONAL MEDICAL CENTER If Under 24 Hrs. If Under 1 Year 5. Social Security Number 8. Date of Birth (Month, Day, Year) Nov. 7, 1956 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 10XM 20 F 43 Yes Director 214-60-8897 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Wicomico Salisbury Directo Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 238 28712 Ocean Gateway 21801 LISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 M No if Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married b Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced filed within 72 hours Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 333-09 Elementery/Secondary (0-12) College (1-4or 5+) 12th grade laborer Dove Point 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be nent of Health and Mental John Clifford Postley, Sr. Laura Jester 19e. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Health a Important: If Item 27 Is any injury or other tra Christine H. Postley/wife 28712 Ocean Gateway - Salisbury, MD 21801 Baltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Garden 6/23/00 Hebron, Maryland Signature of Funerat Service Licer 22. Name and Address of Facility 1213 Jersey Road - Salisbury, MD 21801 JOLLEY MEMORIAL CHAPEL that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate thtervat Betwean Onset and Death 23a. Part1. Enter the disease, or com shock, or heart feiture. List only **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Examiner 10 m Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last physician s the buria P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the causa of death? Unknown cate has been signed by page 2 should be detac 1 Yas 2 No 3 Probably Records. þ Be Completed 24b. Were autopsy findings available prior to 24a. Was en eutopsy performed? completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: 25. Wes case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 30 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation After To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year) 1 30743 anne 30. Name and address of person who completed cause of death (Item/23a) (Type, Print) H. Meyer SHOVE Dr. M.1 400 mo EASTERN SALISBUIN, 31. Dete filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 0 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle Last) 2. Date of Death 3. Time of Death **Physician** June 17, 2000 KAREN DAUGHERTY PHILLIPS 6:51 PM /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1107 Frederick Ave. Salisbury Wicomico If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 8. Data of Birth Month, Day, Year) June 19,1963 7. Age (In yrs. last birthday) 9. Birthplaca (Stata or Foraign **Funeral** 1□M 2⊠F Mary Land 217-54-5388 Yrs. Director Usual Residence of Decedent the Manyland 10s. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits Wicomico Maryland Salisbury 1 Vas 2 □ No Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 8 1107 Frederick Ave. 21801 ž USA Funeral 12. Was Decedent Ever in U,S.
Armed Forces?
1 ☐ Yas 2 ◯ No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) 11. Marital Status 14. Race - American Indian. Black, Whita, atc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0020 'natural', or 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Regional Planner State Agency 17. Father's Nama (First, Middle, Last) 18. Mother's Nema (First, Middle, Maiden Surnama) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If them 27 is marked oth dury or other traumatic even 8 Wayne M. Daugherty Betty A. Henderson 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Department of Health as Important: If them 27 is any Injury or other tras-ance. 1107 Frederick Ave., Salisbury, MD 21801 Daniel K. Phillips/Husband 20b. Place of Disposition (Nama of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1⊠ Buriaf 2 ☐ Cremation 3 ☐ Removel from Stata 4 ☐ Donation 5 ☐ Other (Specify) Wicomico Memorial Park 6/21/00 Salisbury, MD 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 21. Signature of Funeral Service Licensee sume 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilura. List only one cause on each line. Approximate tritervel Between Onsat and Death **Physician** Immediata Causa (Final diseasa or condition resulting in death) /Medical Carcinona Examiner Dua to (or as a consequence of). Physician/Medical Examiner The law requires that the death certificata be executed use as the burial-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequence of): Box 68760. Dua to (or as a consequence of): P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown signed I Records. ģ 24b. Wara autopsy findings available prior to complation of cause of death? Completed 24e. Was an autopsy peen page 2 certificate 1 ☐ Yas 🎾 No 1 ☐ Yas 2 ☐ No of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the funeral director; the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function Be 25. Was casa refarred to medical 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Besidence 6 Othar (Specify) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 PA edical Certification: To 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 Matural 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and little of certifier 29c. License number 29d. Dala signed (Month, Day, Year) ent M.D. 030690 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

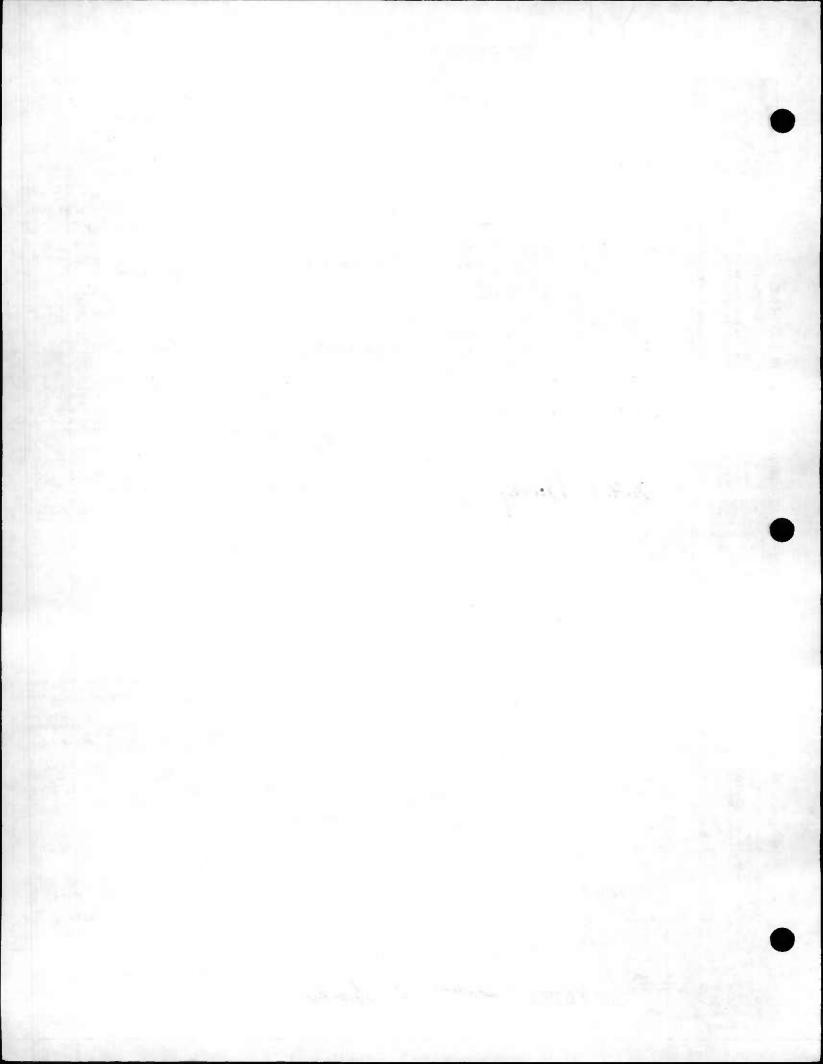
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State Registrar 145, E.

Carroll St. Salisbury, MO.

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31. Date filed (Month, Day, Year) 2000



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death July 5 2000 Brice DeWitt Renn 4:00 am 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 4610 Sandy Spring Road Burtonsville Montgomery If Under 1 Year Birthplece (State or Foreign Country) If Under 24 Hrs. 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Year) Months Deys Hours 1XM 2□ F Yrs. 214-18-2345 81 Jan.2, 1919 Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Burtonsville Montgomery 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 4610 Sandy Spring Road 20866 USA 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-It Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien, Bleck, White, etc. 11. Marital Status 1 ☐ Yes 2 ▼No if Yes, Give Yeer or Detes: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White 3 XWidowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Agriculture Farmer 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) William D.c. Renn Alice Connell 19e. Intorment's Name/Relationship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) 15200 McKnew Road, Burtonsville, MD, 20866 Robert Renn/Son 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/8/00 Union Cemetery Burtonsville, MD 21. Signeture of Funeral Service Licensee 22. Neme end Address of Fecility Donaldson Funeral Home, P.A. MOO770 313 Talbott Avenue, Laurel, MD, 20707 23e. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Deeth Immediate Ceuse (Finel disease or condition resulting in death) L How Ary CorTon/89 Due to (or es e consequence ot): Sequentielly list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in deeth) Lest Due to (or es e consequence ot): Due to (or es e consequence ot) Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy tindings eveilable prior to completion of cause of deeth? 24a. Was en autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was cese reterred to medical examiner? 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Matural Injury 1 ☐ Yes 2 ☐ No 2 Accident

requires that the death certificate be executed attending physician and for use as the burial-trant P.O. Box 68760, detached signed by to Records, peen The law page 2 certificate has Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

Physician

· /Medical

Examiner

Director

Funeral

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Completed

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Physician/Medical Examiner

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Certification:

Medical

3 Suicide

29a, Certifier

4 Homicide

Funeral

Director

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural," or items 23a or 28a-f show any injury or other traumatic event, the Medical Examplest must be notified at once.

Physician

Medical

Examiner

Baltimore, Maryland 21215-0020

PO

1 critifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the ceuse(s) end menner es stated.

2 Madical Examiner: On the best of exeminetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) end menner stated. 29c. License number 29d. Date signed (Month, Day, Year) end title of certifier 2000 ul dapal

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

30. Name end eddress of person who completed ceuse of deeth (Item 23a) (Type, Print)

6 Could not be determined

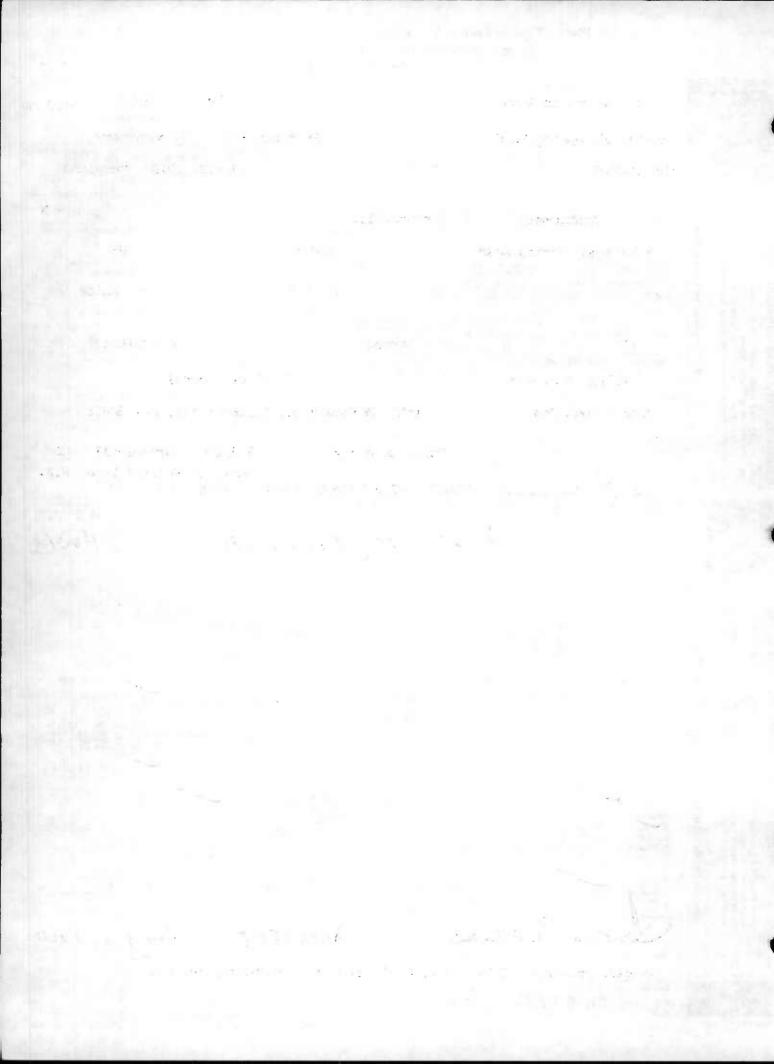
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3905 National Blvd. Burtonsville, Md. Deepak Cuddapada, M.D. 31. Date filed (Month, Day, Year)

State Registrar 32. Registrar's Signeture

28e. Plece of Injury - At home, tarm, street, fectory, office building, etc. (Specify)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Roberts Dorothy H. 25-6-2000 10:30PM 4a. Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Warwick Cecil Graham Nursing Home If Under 1 Yeer Months Days If Under 24 Hrs. 5. Social Security Number 9. Birthplace (Stete or Foreign Country) Delaware 7. Age (In yrs. last birthdey) Hours 1 M 2 F Yrs 90 213-24-1696 Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No New Castle Delaware Odessa 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code P.O. Box 278 19730 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 11. Maritel Stetus Wes Decedent of Hispanic Origin? (Specify Yes or No-lt Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify Specify: 3 Widowed 4 ☐ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coilege (1-4or 5+) Bank Teller Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Joseph C. Hutchison Blanche Cahoon 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code, 278 Odessa, De. 19730 Jeanne Buckworth P.O. Box 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, State 6-29-00 Townsend Cemetery Townsend , De. 21. Signature of Funeral Service Licenses 22. Neme and Address of Facility 212 N. Broad St Daniels & Hutchison Middletown, De. 23d. Part 1. Enter the disease, or complications that caused the death shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death Do not enter the mode of dying, such as cerdiec or respiratory errest, Immediate Cause (Final disease or condition resulting in death) COPD Due to (or es a consequence of) Sequentially list conditions, If any, leading to Immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequenca of): Due to (or as a consequence of) Pert tt. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No 24b. Were autopsy tindings eveileble prior to completion of ceuse of death? 24a. Was an autopsy PARKINSONS dz 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case reterred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No

Physician /Medical Examiner

Examiner

Physician/Medical

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Completed

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Certification:

Medical

27. Magner of Death

1 Natural

3 Suicide

29a, Certifier

2 Accident

4 ☐ Homicide

(Check only one)

29b. Signatore and title of conflier

JUN 2 8 2000

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

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7 is marked other than "natural", or items 23s or 28s-f shor traumatic event, the Medical Examiner must be notified at

al Hygiene.

permit. Peges 1 and 2 should be file Depertment of Health end Mental Hy important: if Item 27 is marked othn any injury or other traumatic event

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filed within 72 hours efter

Baltimore, Maryland 21215-0020

signed by the ettending physician and d be deteched for use as the buriel-transit

Records, P.O. Box 68760

Division of VItal

requires that the death certificate be certificate hes spital or Attending Phys hours efter death. neral Director: After this y filled in by the funeral di this To the Hospital or within 24 hours eff To the Funeral Di completely filled in

31. Date filed (Month, Day, Year) State Registrar

William Covell

5 Pending Investigation

6 Could not be determined

28e. Place of Injury - At home, tarm, street, factory, office bullding, etc. (Specify)

28b. Time of

118 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Dey, Year)

28d. Describe how injury occurred

28t. Location (Street end Number or Rural Route Number, City or Town, Stete)

2595000 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print)

28a. Date of tnjury (Month, Dey Year)

Middletown Do 19709 BRUAD St. 418

28c. Injury at Work?

1 Yes

32. Registrar's Signature

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DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

JUN 2 0 2000

32. Registrar's Signature

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Month 2245 **Physician** 2000 22 Doris Leona Southerington June /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Daeth Examiner Fallston General Hospital Fallston If Under 24 Hrs. Harford If Under 1 Year 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Days 1 M 25 F Yrs. 217-20-0268 Usual Residence of Decede Sept.9,1923 Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Directo Maryland Harford Joppa. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 408 Gilmore Road 21085 USA 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes: 1 Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: Specify: 3 Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Henry H. Ruttinger Doris Leona (UK) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 408 Gilmore Road, Joppa, Maryland 21085 Henry L. Southerington-son 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State June26,2000 Baltimore, Maryland N Burial 2 ☐ Cremetion 3 ☐ Removel from State Donation 5 Other (Specify) Lorraine Park Cemetery 22. Name end Address of Facility McComas Funeral Home, P.A. re of Funeral & 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part1. Enter the disease, or com shock, or heart teilure. List only plications that cause one change on which is ed the death. Do not enter the mode of dying, such es cerdiac or respiratory errest, Approximete Interval Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Cerebrovassu Due to (or as e consequence of): Examiner enol Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were autopsy findings aveilable prior to completion of cause of death? Completed 24s. Wes an autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Describe how injury occurred 28b. Time of

nding physicien and use as the buriel-transit been signed to Records, page 2 certificate of Vitai To the Hospital or Attending Physicien: within 24 hours effer deeth.

To the Funeral Director: After this cartifica completely filled in by the funeral director; to Certification: To Division

Funeral

Director

d 2 should be filled within 72 hours efter deeth with the Marylan th and Mentel Hyglene.
7 le marked other then "natural", or Nama 23a or 28a-f show traumatic event, the Medical Examinar must be notified at

permit. Peges 1 and 2 should be flie Department of Heelth and Mentel Hy Important: If Item 27 is marked othe any Injury or other traumatic event ansa.

Physician

/Medical

Examiner

Baitimore, Maryland 21215-0020

Leona

Doris

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Jouthering

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 29a. Certifier

12 Certifying Physician: To the bast of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

Kness 30. Name and address of person who completed cause of death (flored 234) (Type, Print)

Craig M. Shaughnessy, 104 Plumtree #115, Bel Air, MD 21015

D30078

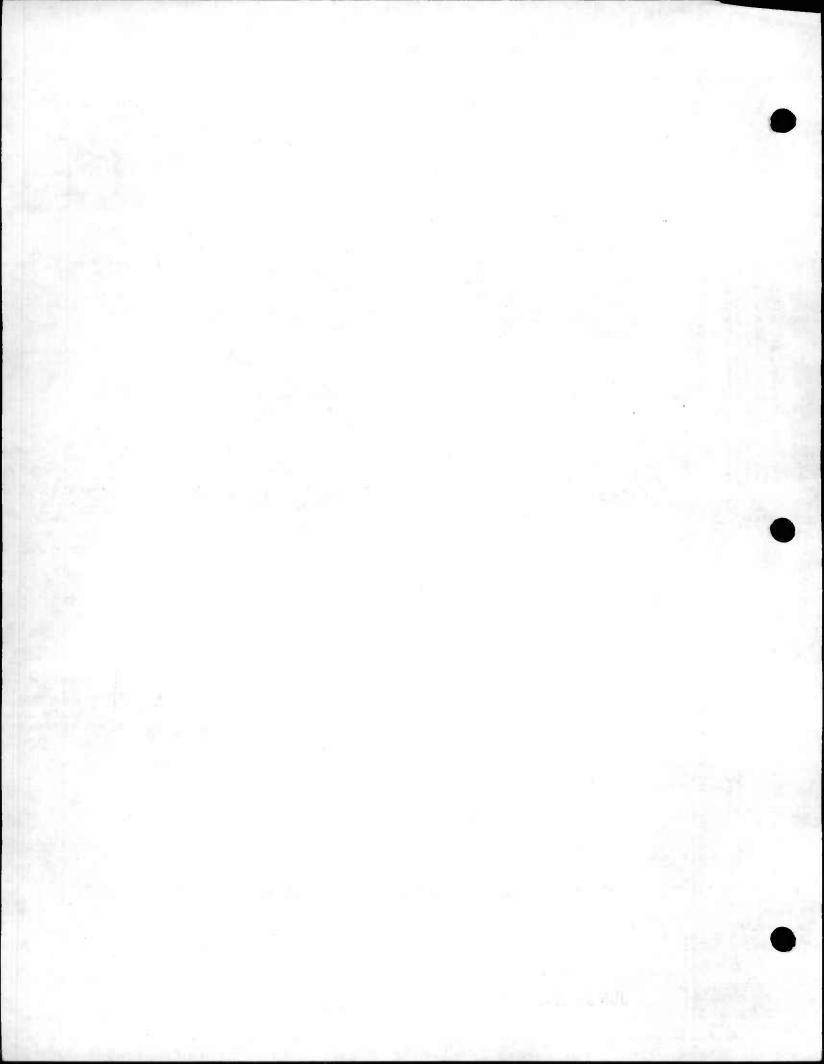
June 23

2000

31. Date filed (Mooth, Pay Year) 2000

32 Registrar's Signature

Medical



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Van Elizabeth M. Schussler June 27, 2000 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Baltimore Kosedale ranklin nter Square Hosbital H Under 24 Hrs. 8. Dete of Birth Hours Min. 06 Hontin Day Year) 7. Ade (In yrs. last birthday) If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 1 M 2 K F Deys Months Marilland 218-12-2298 Usual Residence of Decedent 10a Stete 10b County 10c. City, Town or Location 10d. tnside City Llmits 1 ☐ Yes 2 No Maryland Baltimore Baltimore 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? 7232 German Hill Road 21222 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 Ø No if Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify. Specify 3 Widowed 4 □ Divorced Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Charles Schiefer Elizabeth Kvet 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. tnformant's Name/Relationship (Type, Print) Mr. Charles Schussler/Son 6 Pierson Court, Bear, Delaware 20b. Place of Disposition (Neme of cemetery, cremetory or other place. 20c. Location - City or Town, Stete 20a. Method of Disposition 1 ☐ Burial 2 🖄 Cremation 3 ☐ Removal from State Ferris Crematory 7/5/00 West Chester. PA 4 ☐ Donetion 5 ☐ Other (Specify) Davied Name and Address of Focility Schimunek Funeral Home of Bel Air, Inc., 610 West MacPhail Road, Bel Air, Maryland 21014 of Funeral Service Licensee Christina L. Approximate Interval Between Onset end Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in deeth) Hours e to (or es e consequença of) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last eudoMonas 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 24b. Were autopsy findings aveileble prior to completion of cause of death?

Physician /Medical Examiner

Physician

/Medical

Examiner

Funeral Director

Be Completed by

Funeral

Director

Maryland 21215-0020

altimore,

Box 68760

P.0.

Division of Vital Records.

The law requires that the death certificate

Pages 1 and 2 should be sent of Health and Mental

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physician the burial Physician/Medical 88 980 by Completed Be After this

edical Certification: To To the Hospital or Attending Pt within 24 hours after deeth.
To the Funeral Director: After th completely filled in by the funeral

Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of tnjury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 Suicide Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide

29a. Certifier

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated.

29b. Signature and title of cartifier

29c. License number

29d. Date signed (Month, Dev. Year)

Baltimore, Maryland

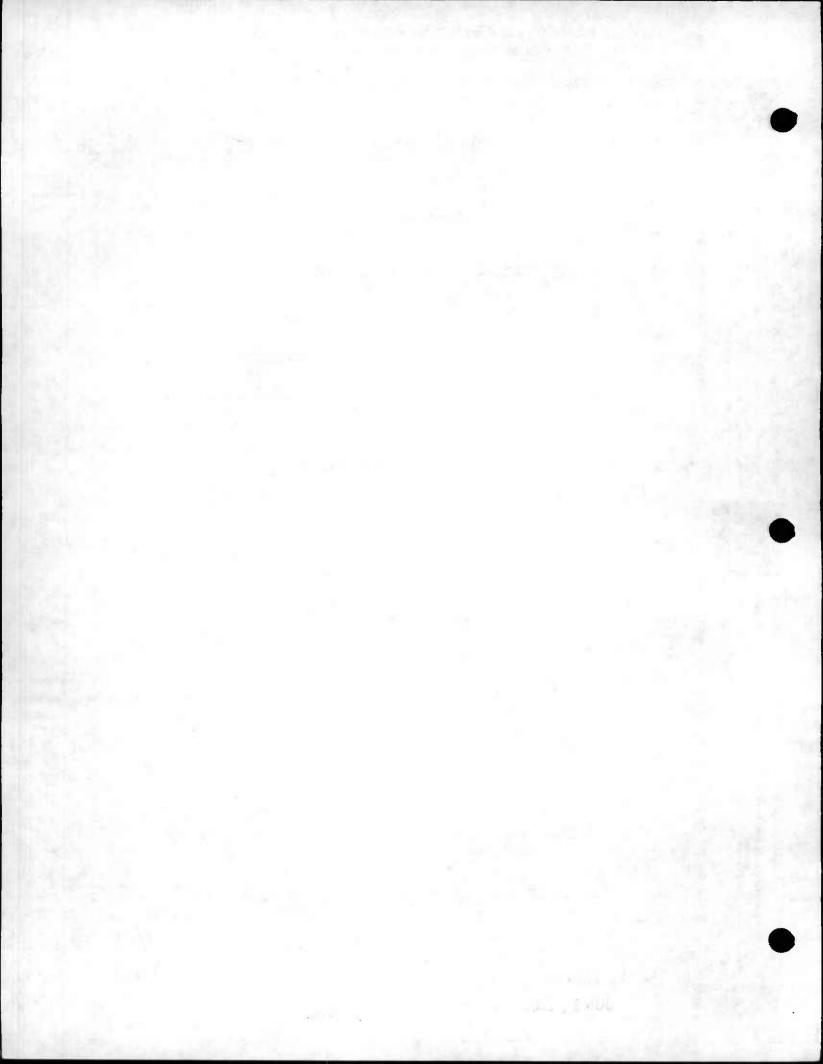
who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 9000 Franklin Square Dru

State

JUN 3 Q 2000

32. Registrar's Signature

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month ARRIE JUNE 15, sow 2100 TURGIS 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Date of Birth (Month, Dey, Year) Months Days Hours 1□M 2KF Yrs. MD220-01-7256 **Uauel Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits SALISBUR 1 Tyes 2 No WICOMICO 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 28475-EAN USA GATEWAY 21804 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S Armed Forces? 14. Rece - American Indien, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: BLACK 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) INE WORKER AMOBELL 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HNNIE LEDDICK PURNELL PURNELL 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 28475 - OCEAN GATENAY SALIS BURY MD. 21804 Date 200 Location - City or Town, State JAMES . LONES 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State 6/21/2000 FRIENDSHIP U.M. CHURCH 4 ☐ Donation 5 ☐ Other (Specify) In al Funeral Service Licansee 22. Name and Address of Fecility BENNIE SMITH ST. SAUSBURY 917.W. ISABÉLLE Mp. 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) 4 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Dlaease or Injury that initiated events resulting in death) Last Due to (or as e consequenca of) Due to (or es e consequence of): Part II. Quid significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23b. Dtd tobacco use contribute to the cause of death? 1 Yes DNO 3 Probably 4 Unknown 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medicat examiner? 26. Plece of Deeth (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 9 No Pinpatient 2 ER/Outpatient 3 DOA 27 Menner of Deeth 28a. Dete of tnjury (Month, Day Year) 28b. Time of 28c. tnjury et Work? 28d. Describe how Injury occurred Naturat 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, atreet, factory, office building, etc. (Specify)

The lew requires that the death certificate be axecuted Box 68760. P.O. of Vital Records. or Attending Physician: Division

Medicai Certification: within 24 hours efter death. To the Funeral Diractor: Af completaly filled in by the fu To the Hospital Tendri

Physician

/Medical

Examiner

Funeral

Director

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Physician /Medicat

Examiner

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After this funerai

other traumatic avant, the Medical Examiner must be notified at

filed within 72 hours after

21215-0020

Maryland

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Funeral Director

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Completed

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Completed by Physician/Medical Examiner

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4 Homicide

31. Date filed (Month, Day, Year)

29a. Certifier (Check only 29b. Signature and title of

State Registrar

30. Name address of person who completed cause of death (Item 23a) (Type, Print) 5. M.D Khan Kazı

JUN 2 0 2000

54 32. Redistrer's Signature

29c. License number

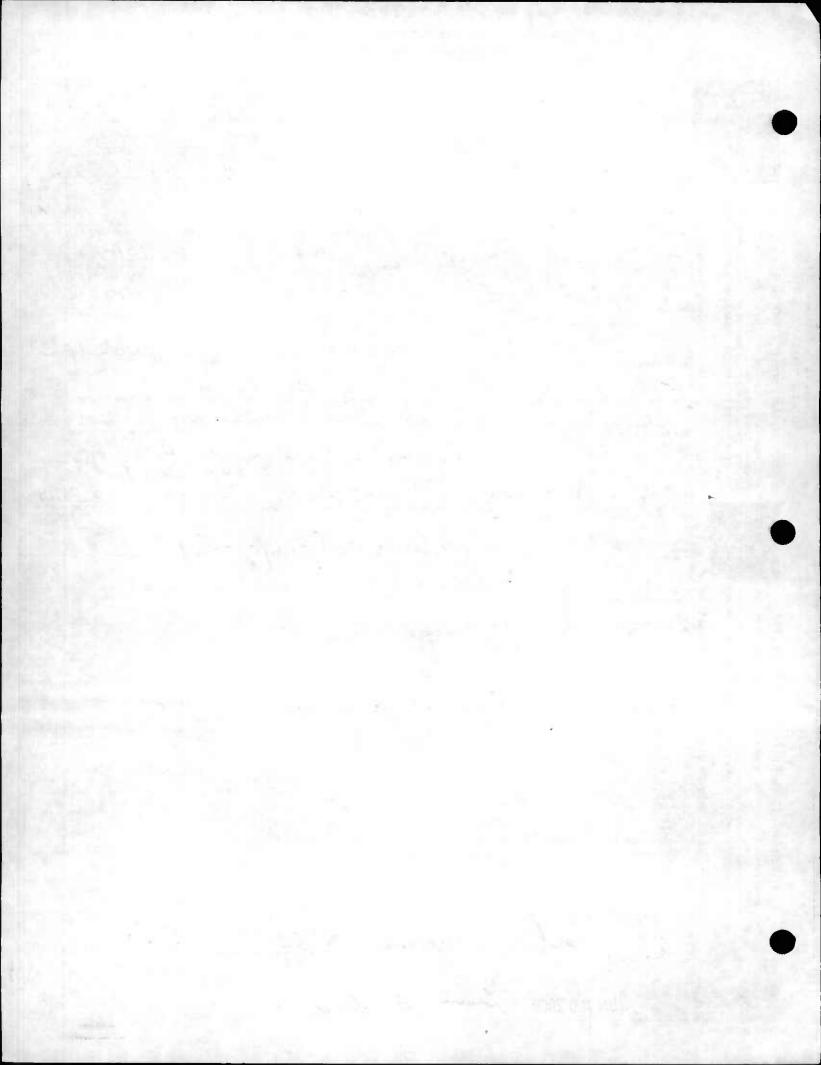
29d. Date signed (Month, Day, Year)

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Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated.

Carifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22136

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Physician		Decedent's Nama (First, Mide						133			2. Dete of D		Dey	Year	3. Time of Death
/Medical		Margaret										21,	2000		11:45 P.
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184 27 2000 James J. Harris

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** James JUNE 18 2000 /Medical 5:55 am 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ANNE ANNAPOLIS ar If Under 24 Hrs. T7 ANNAPOLIS ARUNDEL DRIVE APT 1035 NORMAN If Under 1 Year 8. Date of Birth (Month, Day, Year) AUG . 5 19 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1€ M 2□ F Days Yrs. 69 1930 Director MARYLAND 218-26-0350 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahon permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or flems 23a or 28e-f show any injury or other traumatic event, the Medical Examiner must be nottled at page. 1X Yes 2 □ No Directo MARYLAND ANNE ARUNDEL ANNAPOLIS 10f. Zip Code 10g. Citizen of What Country? 1035 NORMAN DRIVE APT. 21403 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 XYes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 If Yes, Giva Year or Datas: 1953 1 ☐ Yes 2 ☑ No Specify: Specify: BLACK ğ 3 Widowed X Divorced Completed 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 8th COOK US NAVAL ACADEMY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be JAMES WESLEY SMOTHERS GRACE DAVIS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21403 19a. Informant's Name/Relationship (Type, Print) 1035 NORMAN DR. APT. T7 ANNAPOLIS, MD. NORMA BRASHEARS (FRIEND) 20b. Place of Disposition (Name of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ABurlal 2 Cremation 3 Removal from State MARYLAND VETERAN 6/23/00 CROWNSVILLE, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee MO0 483 22. Name and Address of Facility WM. REESE & SONS MUKTUART,

821 WEST ST. ANNAPOLIS, MD. 21401
Approximate Interval Between Onset and Death Lavy 23a. Part1. Enter the disease, or complications that ceused the death. Do not en shock, or heart failure. List only one cause on each line. Physician Prostate Cancer Immediate Cause (Final disease or condition rasulting in death) /Medical 1001 **Examiner** Due to (or as a consequence of) The law requires that the death certificate be executed Sequantially list conditions, if any, leading to immediate ceuse. Entar Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the causs of death? Division of Vital Records, P.O. 1 Yss 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of ceuse of death? 2000 1 ☐ Yas 2 ☐ No certificate 1 Yes the Hospital or Attending Physician: 25. Was cese referred to medical axaminer? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this funerel 27. Manner of Death 1. Divatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After t Certification: 5 Pending invastigation ours after death. eral Director: Al filled in by the fu 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C completely filled Tecrtifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura and title of certifiar Ellen Weises D52830 June 22,2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) Road, #300, Annopalu, MD 21401 Jeanine Werner, 900 Besteak

State Registrar

JUN 2 7 2000

31. Date filed (Month, Day, Year)

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death 2000 June 23 **Physician** Gloria Elaine Simpson 5:30 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Genesis Eldercare - Spa Creek Center Annapolis Anne Arundel If Under 24 Hrs. Hours Min. 8. Date of Birth (Month, Dey, Year) April 10,1944 If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. lest birthday) Birthplace (State or Foreign Country) **Funeral** 1□,M 2₺ F Months Days 56 159-36-6196 Maryland Director Usual Residence of Decedant death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits show other traumatic event, the Medical Examiner must be notified at 1 ☐Yes 2 ☐ No Funeral Director Anne Arundel Annapolis or items 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 21401 170 Green Street USA permit. Pages 1 and 2 should be filed within 72 hours after dea. Depertment of Health and Mental Hyglene. Important: If item 27 is marked other than "natural" or any injury or other traumatic event. 14. Race - Amarican Indian, Black, White, atc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 15. Decedant's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) Elemantary/Secondary (0-12) Manager Marketing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Lillian Nemanis Joseph Russell 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Annapolis, MD 21401 Ellen Kallins / Friend 170 Green St. 20b. Place of Disposition (Name of cematery, cremetory or other place) 20a Mathod of Disposition 20c. Location - City or Town, State Dete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 6-26-00 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory Brentwood, Maryland 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility John M = Taylor Funeral Home, Inc. 147 Duke of Gloucester St. Annapolis, MD 21401 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** /Medical immediata Cause (Final Ovarian CAncer disease or condition resulting in death) Examiner Examiner The law requires that the death certificata be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequence of): pue Box 68760. attending physiclen Physician/Medicai the Due to (or as a consequence of): signed by the attending p d be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco uss contributs to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Wara autopsy findings available prior to 24e. Was an autopsy performed? completion of causa of death? After this certificate has page 2 1 Yes 2 No 1 ☐ Yes 2 ☐ No tal or Attending Physician: To a shar death.

al Director: After this certificatied in by the funeral director, p 25. Was case rafarred to medical axaminer? edicai Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 5 Residence 6 Other (Specify) 1 Yas 2 No 28a. Date of Injury (Month, Dey Year) 27. Mannar of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 TYes 2 No 2 Accident 8 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 D Homicida To the Hospital within 24 hours a To the Funeral I 1 Certifying Physician: To the best of my knowledge, daath occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

completely

(Check only one)

(90

29b. Signature and tipe of certifie

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

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29c. License number

29d. Date signed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Katherine (MMN) Tanzola June 21, 2000 1:33 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Deeth 4c. County of Death Examiner Gilchrist Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Sacurity Number 8. Data of Birth (Month, Day, Year) Dec. 14, 1919 8. Birthplace (State or Foreign Country) Tindiana 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2\ F Months Hours 80 317-03-9279 Director (3 Usual Residence of Dacedant 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits -2000 Maryland Harford Yes 2 No Bel Air Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 344 Harlan Street 21014 238 USA Funeral 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☑ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Marital Status 14. Raca - American Indian, Black, White, atc. 1 ☐ Never Marriad 2 ☐ Married JUNE-21 Maryland 21215-0020 natural, or 1 ☐ Yes 2 ☑ No Specify: White py 3 ☐ Widowed 4 ➡ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 18a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiane. College (1-4or 5+) 5+ Elementary/Secondery (0-12) Addiction Counselor Counseling 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be should be and Mental P merked Harry A. Pouder Edna Pouder Potter 19a. Informant's Name/Raletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 is n Mary Jo Pons/Friend Country Life Estate, POB 107, Bel Air, MD 21014 ATHARINE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Hilltop Service Corp. 6-26-00 Towson, Maryland 21. Sign 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009 23a. Part1. Enter the disaasa, or complications the faused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrast, shock, or heart failura. List only ona cause of and line. Approximate Interval Batwean Onset and Death **Physician** /Medical Immediate Cause (Final CANCEV I months disease or condition resulting in death) Examiner Due to (or as a consequence of) Examine Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseasa or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. P.0. 23b. Did tobacco use contribute to the cause of death? The law requires thet the 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, by 24b. Wera autopsy findings available prior to completion of cause of daath? Completed 24a. Was en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No Division of Vital Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 ☐ Residence 6 Mother (Specify) 2 1 Yas 2 No 27. Mannar of Death 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: After or Attending 5 Pending 1 Natural deeth. 1 ☐ Yes 2 ☐ No investigation 2 Accident after deeth Director: / d in by the f 3 Suicida 6 Could not be determined 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C completely filled edical 29a. Certifier 1 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signatura An uno 83a) (Type, Print) cause of death (Ue V. Charle St. Calto. md 21205 6701

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31. Date filed (Month, Day, Year)

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Registrar's Signeture

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		Name (First, Middle, Li	nst)	Track Est				2. Date of De Month	eth Day	Year	3. Time of Death
Physician /Medical	Francis	S Oscar Th		r.			4b. City, Town, or I	June	22 20	00	9:50am
Examiner	Harfor	d Memorial	Hospital		de al Mille	der 1 Yea	Havre de	Grace	Hart	ford	
Funeral Director	5. Social Secur	-2075	Sex 7. Age	79 Y	Mont						
and and	10a. State	ce of Decedent 10b. County		10c. City, Town	or Location					1	0d. Inside City Limits
he Mary	MD	Harfor	d	Aberd							1)X Yes 2□ No
death with the Manyland ma 23s or 28s-f show mans be notified at meral Director	10e. Street and 720 CIa	ayton Stree	et			Zip Code 2 1 0 0 1		10g. Citizen of What Country? USA			itry?
Territor Her	3 ☐ Widow		12. Was Decedent I Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	lo	If Yes, s	ecedent of specify Cul s 2X No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or No o Rican, etc.)		e - Americ ck, White, v: W	
Maryland 21215-002C d2 should be filed within 72 hours at the and Mental Hygiene. 77 is marked other than "natural", on the unstite event, the Medical Exercision To Be Completed by I	(15. Decedent's E Specify only highest gr	ducation ade completed)	16a. C	Decedent's U Give kind of	sual Occu	pation during most of wor	king	16b. Kind of B	usiness/Inc	dustry
2121 d within giene. r than r	Elementary/	Secondary (0-12)	College (1-4or 5	+) _			9d)		Carron	m m c m	
d 2 Hygied v mr. III of	17 Father's Na	ame (First, Middle, Las	3 years	E	ngine	er	18. Mother's Nan	ne /First Middle	Gover		I L
Aaryland 2 should be filed and Mental Hygis is marked other reumstic event, I		s Oscar Th		r					, maiodir Damaii	,	
thould by Men marke		t'a Name/Relationship			Mailing Add	ess (Stree	Carrie		per City or Town	State Zin	Code)
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re, N 1 and 3 Health tem 27	20a. Method of		on wite	20b. Place of D	Disposition /	Name of		Date	20c. Location		wn, State
Baltimore, Maryland ; permit. Pages 1 and 2 should be file. Department of Health and Mental thy important; if them 27 is marked other any injury or other traumatic event, once.		2 ☐ Cremation 3 [ion 5 ☐ Other (Speci			r Men		Grdns.	6/26/00	Bel Air	, NiD	
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Division of the or Attending Prise or Attending Prise of the train Director; After teled in by the funers Certification:	3 Suicid	e 6 ☐ Could not b	28e. Placa of Inju- building, etc	iry - At home, farn (Specify)	n, street, fac	tory, office		28f. Location City or To	(Street and Number, State)	ber or Rura	I Route Number,
Division or To the Hospital or Attending Phywithin 24 hours after death. To the Funeral Director: After this completely filled in by the funeral Medical Certification:	29a. Certifier (Check onl	160 Certifying Pi	nysician: To the best of	f my knowledge,	death occur	red at the	lime, date and place	, and due to the	cause(s) and m	anner as s	tated.
he Hosplin 24 hours he Funer pletaly fill		7 2 Li Medicai Exai	niner: On the basis of and manner sta	ted.	or investigat	tion, in my	opinion, death occu	irred at the time,	, date and place,	and due to	the cause(s)
To the to the com	29b. Signature	and title of-certifier	W			29c. Licer	712		Col 23	d (Month,	Day, Year)
15	30. Name and	address of person who	completed cause of de	eeth (Item 23a) (T	ype, Print)	100	ARIE	LEFFEL	CIAN 1	2.00	
State	Contract to the	Month, Day, Year)		ur'a Signature	ruc	TUP	(1000	uppr	, vvu	- (
Registrar		IUN 2 6 2000	pen	19.	100	acker	/				

DHMH 16 Rev 6/95

Thompson, Francis

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State of Maryland / Department of Health and Mental Hygiene 1 2214

						Certific	ale or	Dealli		Reg. No.		
			1. Decedant's Name (First, Middle, La	st)					2. Dete of De	eth		3. Time of Death
	Physici /Medic		IMO	JE	AN	T	ROUI		June	Dey 23	Yeer 2000]	:45 AM
	Examir		4a. Fecility Neme (If not institution, giv	e street end number)				4b. City, Town, or L				
			1644 Jerrys	Road				Str	eet		Harfo	ord
	Funeral Director		5. Sociel Security Number 6. S 215–50–7132	Sex 7. Ag	e (In yrs. lest bi	Yrs. If Un Monti	der 1 Yeer hs Deys	If Under 24 Hrs. Hours Min.	8. Dete of Birt Month, De 2/17/	n Year) 1906	9. Birthplec Country Mary	e (Stete or Foreign 7land
5			Usuel Residence of Decedent 10e. Stete 10b. County		10 01 7							
d 21215-0020 filed within 72 hours after death with the Maryland	r 28a-f show	Director	MD. Harf	ord	10c. City, Tow	vn or Location		Stree	t			Insida City Limits 1 ☐ Yes 2 2 No
£	or 28	Sire.	10e. Street end Number			10f.	Zip Coda			10g. Citizen of	Whet Country	?
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9	naturel.	ted	15. Decedent's Ed	ducetion	18e	. Decedent's U	suel Occup	pation		18b. Kind of B	usinass/Indus	try
21215-0020 d within 72 hours af	al Hygiene. I other than "n vent, i've Med	Be Completed	(Specify only highast green Elementery/Secondary (0-12)	5+)		work done Tuse ratire	during most of work of the	king		Home		
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			23a. Pert1. Enter tha diseese, or com- shock, or heert failure. List only	plications thet ceuse	death. Do	not enter the n	node of dyi	ng, such es cardiec	or respiretory er	rest,	Ar	pproximete tervel Between
E:	nysician /Medical xaminer	lner	Immediata Cause (Final diseese or condition resulting In death)	. Athero	Sclero			iovascu	Sar d	lisease	te	'n years
x 68760, erificate be axecuted	physician and s tha burial-transit	Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Last	с.	Dua to (or es a							-
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Division of Vital Records,	교	Certification:	3 Suicide 6 Could not be determined		ury - At home, fe c. (Spacify)	erm, street, fac	tory, office		28f. Location (5 City or Tow	Straet and Numi m, Stete)	per or Rurel Re	oute Number,
To the Hospital	24 houn Funers stely fills	edical (29e. Certifier (Check only one) 1 Certifying Ph. 2 Medical Exert	ysicien: To the best of niner: On the basis of and menner ste	axamination an	e, death occurr nd/or invastigat	ed et the ti	me, dete end place, opinion, daath occur	, end due to tha orrad at the tima,	ceuse(s) end m data end place,	enner es stete and dua to the	d. e ceuse(s)
ž	o the		29b. Signeture and title of certifier				29c. Licens	se number		29d. Date signe	d (Month, Des	r, Year)
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٩	12		30. Name and address of person who a	completed ceuse of d	eeth (Item 23e)	(Type, Print)		BEL AI	e Ma	DYI DA	12 2	1014

DHMH 16 Rev 6/95

00-3533-033 jhm CATHERINE THOMPSON

> **Physicia** /Medic Examin

Funeral Director

or items 23s or 28s-f show

other traumatic avant, the Medical Examiner must be notified at

Department of Health and Mental Hygiene Important: If Nem 27 is marked other than any Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumatic swant, are Mental Injury or other traumati

Physician

/Medical

Examiner

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physician the buria

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ate has been signed by the page 2 should be detached

this certificate has

To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I

The law requires that the death certificate be executed

Box 68760

Division of Vital Records, P.O.

þ

Be Completed

2

Examiner

Physician/Medical

Medical Certification: To Be Completed by

Pages 1 and 2 should be filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0020

	Ple		of Maryland / Depa	artmen	t of		and N	fental Hygi			22142
in al er	Decedent's Nema (First, Mid- Catherine P Facility Name (If not institution PARKLANI	roctor T				4b. City, To		2. Date of Death Month JUNE 27 ocation of Death	Day	y of Death	3. Time of Death 14:17 PM EORGES
	5. Social Security Number 2 1 9 - 3 2 - 4 9 4 0 Usual Residence of Decedent	6. Sax 1□ M 2\(\frac{1}{X}\)F	7. Age (In yrs. last birthday) 76 Yrs.	If Undar Months		Days Hours Min. (Month, Day, Year)				piace (Stete or Foreign ntry) yland	
Director	10a. State 10b. Count	10c. City, Town or Lo		e						10d. Inside City Limits 1 ☐ Yes 2 ☑ No	
ınerai Dire	10e. Street and Number 2908 Parkla 11. Marital Status		cedent Ever in U.S. 13. \	Was Deced	747 lent of	7	lgin? (Sp	U:	og. Citizen of nited 14. Rad	Sta	

1 Never Merried 2 Married 3 ₩idowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) unknown

17. Father's Nama (First, Middla, Last)

If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☐ No Specify. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Specify. Black 16b. Kind of Business/Industry

Homemaker

Her Home 18. Mother's Neme (First, Middle, Meiden Sumeme)

James Albert Proctor 19a. Informant's Neme/Relationship (Type, Print)

19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code)

unknown

Catherine Liggins/Niece 20a. Method of Disposition

Same as #10 20b. Place of Disposition (Neme of cemetary, crematory or othar pleca)

200 . Location - City or Town, State Date July

Muriat 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Othar (Specify) St. 21. Signature of Funeral Service Licenses

Ignatius Church Cemetery 22. Name and Address of Facility

20640

Port Tobacco, Maryland

Part If. Other significant conditions contributing to dea

Williams Funeral Home, P.A. 4270 Hawthorne Road, Indian M00668 or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cause on each line.

Head, Maryland Approximate Interval Between Onset and Death

Immediate Cause (Final disease or condition resulting in death)

HEMOPTYSIS

1 Yes 2 No If Yes, Give Year or Dates:

College (1-4or 5+)

Due to (or as a consequenca of):

Due to (or as a consequence of):

Due to (or as a consequenca of):

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

th	but	not	resulting	In the	underly	ring -	cause	given	in Par	t I.

-	23b.	Did tobac	co uee co	ntribute to the c	ause of death?
		1 🗆 Yee	2□ No	3 ☐ Probably	Unknown

29d. Date signed (Month, Dey, Year)

JUNE 28, 2000

24a. Was an autopsy performed?

24b. Were autopsy findings

	164	es
-		

2 No

completion of deeth?	n of causa
Yas	2□ No

25. Was case referred to medi	ical		26. Place of Death (Check only one)							
examiner? 1 ☐ Yes 2 ☐ No	ŀ	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient	3 🗆	DOA Other: 4 Nursing	Home 5 Residence 6 Other (Specify) SCENE				
Z L ACCIONIE	stigation		28b. Time of Injury	М	28c. tnjury at Work? 1 Yes 2 No	28d. Describe how injury occurred				
	ld not be irmined	28e. Place of tnjury - At h building, etc. (Specia	oma, farm, straa fy)	t, fact	ory, office	28f. Location (Street and Number or Rurel Route Number, City or Town, State)				
		77877-3-7757-3-1	Access to the second							

ŀ	29a.	Certifier
Į		(Check o
Į		one)

29b. Signature and title of certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.
22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner steled.

29c, Licensa number OCME

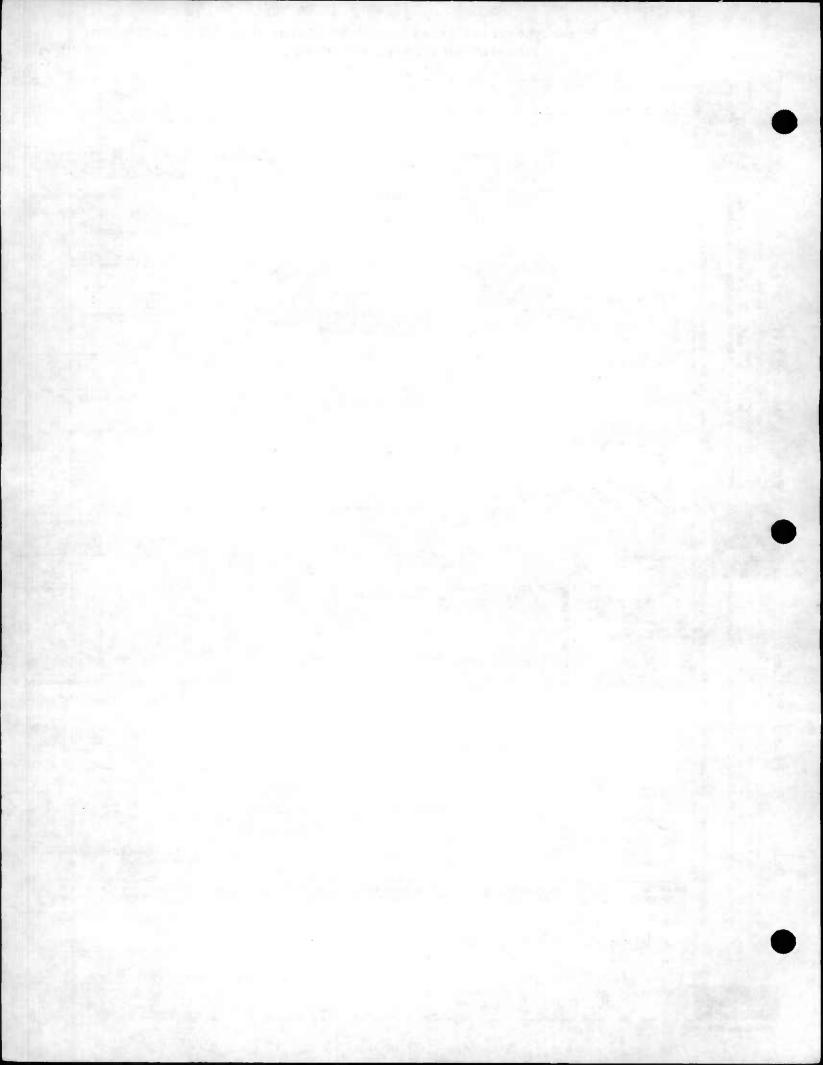
cause of death (Item 23a) (Type, Print)

Penn Street, Baltimore, Maryland 21201

State Registrar

31. Data filed (Month Year) 3 2000 0

32. Registrar's Signature



Please Type or Print in Black indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Year Month WYVETTA M. TARBERT 1022 lune 2000 4a Fecility Nema (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fallston General Hospital Harford Fallston If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 10/30/1909 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Months Days Hours 1□M 200 Yrs. 218-40-1468 90 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits MD Harford Whiteford 1 ☐ Yes 2 XX X6 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1831 Ridge Road 21160 USA 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 3 ☐ No If Yes, Giva Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, atc.) Raca - Amarican Indian, Black, Whita, atc. 11. Meritel Status 1 Never Married 2 Married 1 ☐ Yes 🏖 No Specify: Specify: White **X**SWidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Businass/Industry Elementary/Secondary (0-12) Collage (1-4or 5+) Homemaker 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Simon Beattie Susanna Hughes 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) James O. Tarbert- son 1831 Ridge Rd., Whiteford, MD 21160 20b. Place of Disposition (Name of cemetary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ∰grial 2 □ Cremation 3 □ Ramoval from Stata Slateville Cemetery 6/29/00 Delta, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harkins F.H.Inc.,600 Main St.Delta,PA 23a. Payl. Ental the disease, or complications that caused the death. Approximate Intarval Batween Onset and Death Do not entar the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in daath) Dawe Due to (or as a consequence of): Sequentially tist conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disaase or injury that initiated evants rasulting in death) Last Due to (or as a consequence of): Due to (or es e consequence of): Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Ware autopsy findings evailable prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yas 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical **Examiner**

Physician

/Medical

Examiner

10a. State

Funeral

Director

de or 28e-f show

r than "natural", or items 23a the Medical Examiner must t

permit. Peges 1 and 2 should be filed within 72 hours after c Department of Heelth and Mentel Hygiene, in mortant: if flem 27 is marked other than "natural, or fren eny injury or other traumatic avent, the Medical France

Baltimore, Maryland 21215-0020

Box 68760.

Division

Director

Funeral

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Completed

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Physician/Medical à Completed Be Certification: To

Aher Attending after deat Director: ò 24 hours • Funeral å

Medical within 2 To the

State Registrar

Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and menner stated. (Check only one) 29b. Signature and title of cartifian

5 Pending

investigation

6 Could not be datarmined

25. Was casa rafarred to medical

1 Yes 2 No

27. Mannar of Death

Natural

2 Accident

3 Sulcide

4 Homicida

28a. Data of tnjury (Month, Day Year)

28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D32295

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

26. Place of Death (Check only one)

Other: 4 Nursing Home 5 Residence 8 Other (Specify)

28d. Describe how injury occurred

29d. Date signed (Month, Day, Year) JUNE 28, 2006

28f. Location (Street end Number or Rural Route Number, City or Town, State)

30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print) wood is and 615 W.

31. Dete filed (Month, Day, Year) JUN 2 8 2000 32 Registrar's Signatura

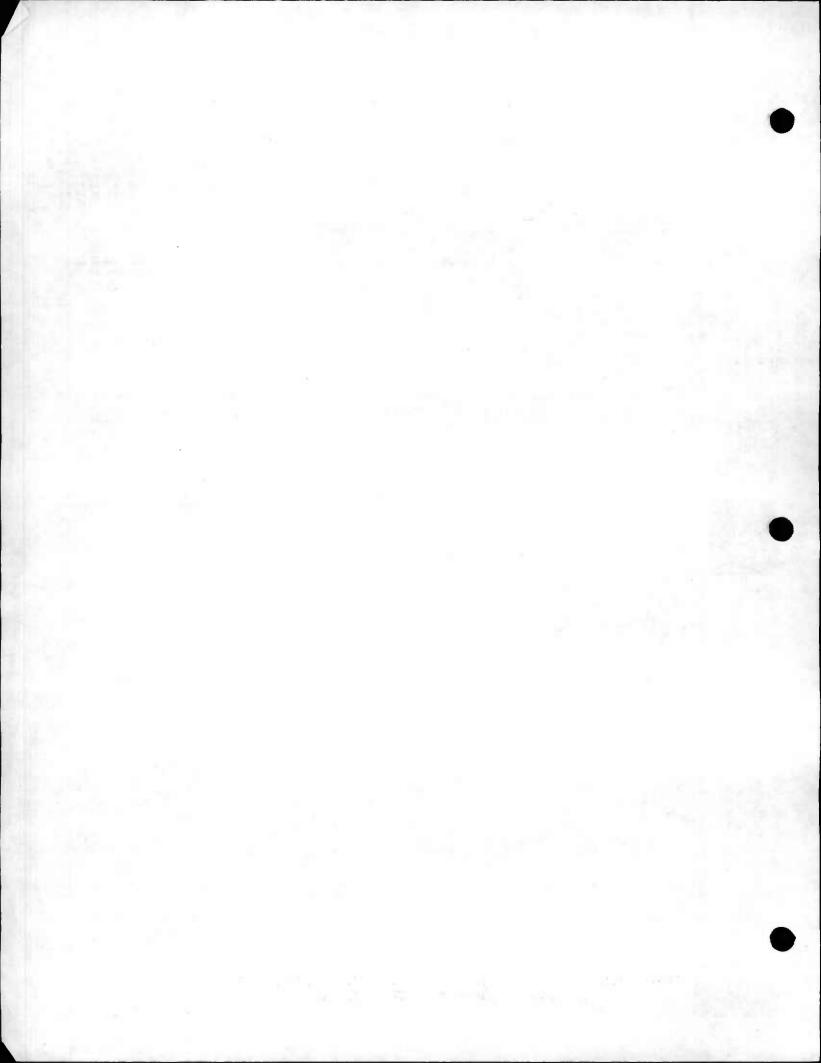
Hospitat: 1 ■ Inpatiant 2 □ ER/Outpatient 3 □ DOA

10 1 1 100

ELISE ADELA TRAMONTI

38760,	
P.O. Box 68760,	
-	
of Vital Records,	
Vital	
of	
Division	1

			State		d / Depa		k. Assure Health and f Death	Mental Hy	/giene Reg. No.	10 22	1 4 4
Physician /Medical	Decedent's Nema (First, Middle, Last) Elise Adela Tramonti							2. Data of Death Month Day Year JUNE 18, 2000 6:30 AM			
Examiner	Months De					If Under 1 Yea	4b. City, Town, or Location of Death SALISBURY, MD WICOMICO Year If Under 24 Hrs. 8. Data of Birth 9. Birtholace (State or Foreign)				
or 28a-1 show a notified at Director	217-14- Usual Rasidance	of Decedent	TOM ZADIF	74	Yrs.			7-16-1	925	M	Id.
or items 23s or 23s-f show miner must be notified at miner must be notified at Funeral Director	Md. Wicomico				0c. City, Town or Location Mardela					10	de City Limits Yes 2 No
ral Dir					10f. Zip Code 21837				i. Citizen of What Country? SA		
5		rrlad 2 Married 4 Divorced	cedent Evar in U orces? 20 No iva Datas:	2\ No 1 Yes 2 \ XN			(Specify Yas or N arto Rican, atc.)	14. Raca - Amarican Indian, Black, White, atc. Specify: White		n,	
Completed	(Spo) (1-4or 5+)	16a. Decedent's Usual Occupation (Give kind of work done during most of w life. DO NOT use retired)			orking	16b. Kind of Business/Industry				
00000	7 17. Father's Nama (First, Middle, Last) Gorman Tull				Beautician 18. Mother's Name (First, Manage Mars)						
_	198. Informant's Name/Ralationship (Type, Print) Michael J. Tramonti, Husband 19b. Malling Address (Street and Number or Rural Route Number, City or Town, Stete, 25049 Ocean Gateway, Mardela, Md. 21837									te.	
	1 Burial 2 Cramation 3 Ramoval from Stata Springhill Memory Garden 6-21-00 Hebron, Md.										It Between and Death
	Sequentially list of it any, laading to cause. Enter Und Cause (Disease of that initiated ever resulting in death	or injury its	b	Dua to (c	or as a conseq	juence of):					
leted by Physician/Medica	/	Ificant conditions of	_					1 = 24a. We	Yes 2□ No s an autopsy formed?	24b. Ware auto available p completion	4 Unknown
e Completed	OF Was once self	arrad to madical							Yas 20 No	of death?	2 No
iffication: To B	axaminar? 1 Yas 2 No								Number,		
Medical Cert	29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated.										
Me							29d. Data signed (Month, Day, Year)				
State Registrar	WILLIAM 31. Data filed (Mo	rass of person who ROBINS, Marth, Dey, Year) JUN 2 1 2	.D. 32.		EALTHW		SALISBURY	, Md.			



Physician

/Medical

Examiner

Director

10a, State

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental hygiens. Important if hem 27 is marked other than "natural", or hams 23s or 28e-1 show any injury or other traumatic event, the Medical Exeminar must be notified as

Physician

Examiner

Physician/Medical Exam

Completed

8

Attanding Physician: The

death.

e Hospital or Attand n 24 hours after death ie Funeral Director: /

To the Hosp within 24 ho To the Fune completely fi

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death as Day Month Year 1-15 PM JUNE Howard Travers Thompson, Jr. 2000 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth GLEN BURNIE ANNE ARUNDEL NORTH ARUNDEL HOSPITAL | H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth | Months | Deys | Hours | Min. | Nov 15, 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) Year) 1948 11 M 2□ F 212-52-4798 Yrs. Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Anne Arundel 1 ☐ Yes 2 No Severna Park 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 112 Evergreen Road 21146 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 (2Yes . 2 □ No 1969 – If Yes, Give Yeer or Detes: 1975 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. 11. Marital Status 1 □ Never Merried 2 □ Married 1 ☐ Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) Water 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Water Treatment Elementary/Secondary (0-12) College (1-4or 5+) Electrician /Treatment Operator 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumame) Howard T. Thompson, Sr. Jean Adrienne Hurd 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 112 Evergreen Road, Severna Park, MD 21146 Jean Adrienne Thompson/ mother 20b. Place of Disposition (Name of cemetery, cremetery or other place) Zion Evangelical June 28 20c. Location - City or Town, Stete 150 Burial 2 Cremetion 3 DRemoval from State Baltimore, MD 4 Donation 6 Other (Specify) Lutheran Church Cemetery 2000 21. Signature of Funeral Service Lice 22. Name end Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home 495 Gov. Ritchie Hwy., Severna Park, MD 21146 tions that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, cause on each line. ACUTE UPPER GASTRO INTESTINAL BLEEDING Immediate Cause (Final disease or condition resulting in death) DAY Due to (or as a consequenca ol): 6 MON THS OF LIVER CIRRHOSIS Due to (or es a consequence of): ABUSE ALCOHOL 20 YEARS Due to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? SYNDROME 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy lindings available prior to completion of cause of deeth? 24e. Was en eutopsy performed?

Sequentially list conditions if any, leading to immediat cause. Enter Underlying Cause (Disease or injury

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

HEPATORENAL

1□ Yes 2□No

25. Was case referred to medical examiner? 1 Yes 2 No 27. Manner of Death

1 DiNatural

2 Accident

3 Suicide

4 ☐ Homicide

28a. Dete of Injury (Month, Day Year) 5 Pending investigation 6 ☐ Could not be

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 28c. Injury at Work? 1 TYes 2 No

28d. Describe how injury occurred 281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

29a. Certifier (Check only one)

1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and place, end due to the ceuse(s) end manner stated.

26. Place of Death (Check only one)

29b. Signature and title of certifier lin, M.D.

29c. License number D46962

29d. Date signed (Month, Dey, Year) JUNE 25, 2000.

1 ☐ Yes 2 ☑ No

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH ARUNDEL HOSPITAL. MD 21061. M. SHIRAZI, M.D.

31. Date filed (Month, Day, Year)

JUN 2 7 2000



State Registrar

JUN 27 2000 Jour D. Aprel

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

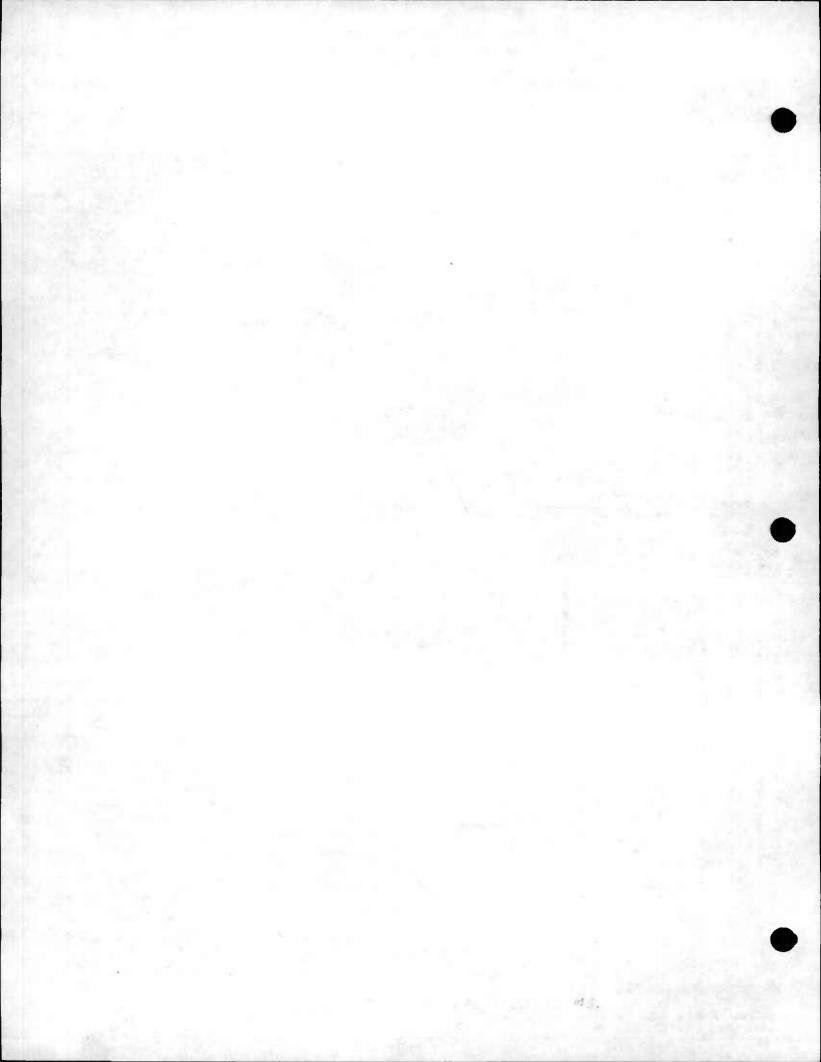
			State of Maryland / Department of Health and Certificate of Death		Reg. No.	0.0	22146
	Dharatat		1. Decedant's Nama (First, Middla, Last)	2. Data of Month		Veer	3. Time of Death
	Physici /Medic		BERT THOMPSON	June	14, 2	000 Yaar	10:35 AM
	Examir		4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, G			County of Death	1
			7006 Berkshire Drive Clinto	n	Pri	nce Geo	orges
	Funeral		5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) If Under 1 Yaar II Under 24 H	rs. 8. Data of	Birth Day, Year)	9. Birth	nplaca (Stata or Foreign
	Director	26	7-07-0013 15 M 2 F 83 Yrs. Months Days Hours Mi	SEPT.	21 1	916 F	LORDIA
	ъ	20	Usual Residence of Decedent				
	how		10a. Steta 10b. County 10c. City, Town or Location				10d. Insida City Limits
	Ma differ	Director	MARYLAND ANNE ARUNDEL ANNAPOLIS				XYas 2□ No
	1) th	ire.	10e. Straat and Number 10f. Zip Coda		10g. Citiza	an ol What Co	untry?
	h wit		163 ACTON ROAD 21403			USA	
	deat	Funeral	11. Marital Status 12. Was Decedant Evar in U,S. 13. Was Decedant of Hispanic Origin?	(Specify Yas or	No- 14	4. Race - Amar	
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Maryland	2 should be and Mental Is marked or raumatic eve	-	19a. Informent's Name/Ralationship (Type, Print) 19b. Malling Addrass (Streat and Number or			Town State 7	in Code)
	alth a 27 is or trac		FLORENCE THOMPSON (WIFE) 163 ACTON RD. ANNA				,
ē,	- SEE		20a. Mathod of Disposition 20b. Place of Disposition (Nama of	Data	т	ation - City or T	Town, Stata
2	nt of		1 ☐ Burial 2 ☐ Cremation 3 ☐ Ramoval Irom Stata cematary, crematory or other place)				
Baltimore,	rtma rtam		4 Donation 5 Other (Specify) METRO CREMATORY	6/26/0	O BAI	TIMOR	E, MD.
Ba	permit. Pagas 'Department of H Important: If ite any injury or of once.		21. Signatura of Funeral Service Licensee MOO483 22. Name and Address of Facility WM . REESE & SO	IOM SMO	אם מוזיים	7 D A	
			Davy S. Deese 8212 WEST ST.				21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerd shock, or heart leafure. List only one cause on each line.	ac or raspirator	y arrast,		Approximata Interval Batween
1	Physician						Onsat and Deeth
	/Medical Examiner		Immediate Causa (Final disease or condition METASTATIC NON SMALL CELL LI	UNG CAI	NCER	1	3 months
ď	Examine		rasulting in deeth) Due to (or as a consequence of):				
	P #	Examiner					
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	daa be at ed fo	Sici	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.	23b. D	ld tobacco u	se contribute	to the cause of death?
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	gn ed	F	PERTENSION, CHRONIC OBSTRUCTIVE PULMONARY	-			
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ō	Phys arthis aral di	닐	27. Manner ol Death 28a. Data of Injury 28b. Tima ol 28c. Injury at		e how Injury		Cexteria_
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	the Hospital hin 24 hours the Funeral nplately filled	edical	(Check only 2 Medical Examinar: On the basis of axamination and/or invastigation, in my opinion, death ocone)	currad at the tim	e, data and p	place, and dua	to the cause(s)
	To the Hospital or within 24 hours after To the Funeral Dir completely filled in	Ψ	29b. Signetura and titla of cepitiar 29c. Licansa number		29d. Data	signad (Month	, Day, Yaar)
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			30. Name and eddrass of person who complated cause of deeth (Itam 23a) (Type, Print) LLOYD KETCHUM, MD WALTER REED ARMY MEDICAL	O TO NATION TO THE	C000	WASH.	
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	Sta	te ar	JUN 2 8 2000 Security Signatura S. Apacks				

DHMH 16 Rav 6/95

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eral			S. Sex	7. Age (In yrs.	iast birthdey)	If Under 1 Ye	ar If Under 24 Hrs	8. Date of B		Birthplace (State or For Country)
ctor	577	7-46-9267	18 M 2□ F	84	Yrs.	Months Da	s Hours Min	Aug. 1	7, 1915 P	ennsylvania
	Usual I	Residence of Decedent tate 10b, County		100 0	ty, Town or Loc					104 (2-14- 0)5-1
10	1000	yland Freder	cick		lkersvi					10d. Inside City L 1 ☐ Yes 2 ☐
rect		treet and Number				10f. Zip Cod	9		10g. Citizen of Wi	hat Country?
2 5	1,100	317 Harp Road				217			U.S.A	
Jera Bra		nital Status	12. Was De	cedent Ever in U	,S. 13. V	Vas Decedent	t Hispanic Origin? (S	Specify Yes or N	o- 14. Raca	- American Indian,
Examiner must be nothing at		Never Married 2 Marrie	Armed F d 1 Yes If Yes, C Year or	2 🔯 No Sive		Yes 211	uban, Mexican, Puar lo <i>Specify:</i>	to Hican, etc.)	Specify:	, White, etc. White
r, re veges! Completed		15. Decedent's		0	16a. Deced	ent's Usual Oc	cupation ne during most of wa	rkina	16b. Kind of Bus	iness/industry
a dr	Eten	nentary/Secondary (0-12)	College	(1-4or 5+)	life. D	OO NOT use re	ired)	riving.		
CO.	17 For	that's Name (First Middle)	6+		P	hysicia		ma /First Mid-	Cardi	
To Be	Fre	ther's Name <i>(First, Middle, La</i> ed Vivino	101/				Louisa		e, Melden Sumema	/
To		ntormant's Name/Reletionshi	o (Type, Print)		19b. Maitin	a Address (Str	eet end Number or R		ber, City or Town 5	Stete, Zip Code)
T tree		an Vivino (Wi					load, Walk			
othe		lethod of Disposition			Place of Dispos	sition (Neme of	nlece)	Date	20c. Location - C	City or Town, State
7 0		☐ Burial 2 【☐ Cremetion 3 ☐ Donetion 5 ☐ Other (Spe		n State		g Crema		6/8/00	Smithsbu	rg, Marylan
any Injury or other traumatic avant, tra Motion. To Be Comp	22. Name and Address of Facility & SON FUNERAL HOM 1201 NORTH MARKET ST., FREDERICK,									
ian ical iner	disees	tmmediate Cause (Final disease or condition resulting in death) a. Stroke Due to (or as a consequence ot): Alzheimemen i Disease								
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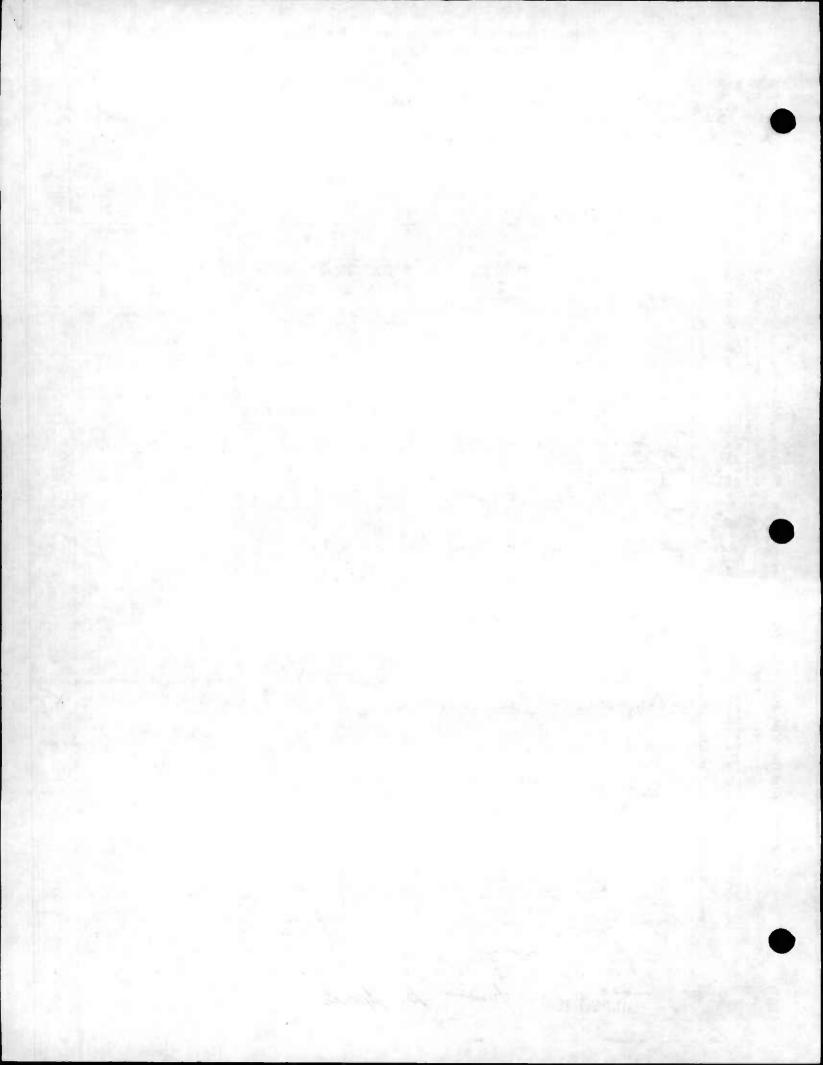


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State of Maryland / Department of Health and Mental Hygiene

	Certifi	icate of Deal	in	Reg. No.	La Ca 7 C	
Physician /Medical	1. Decedent's Name (First, Middle, Last) EDWARD LEE VADEN		2. Dete of De Month June	Dey Year	3. Time of Death	
Examiner	4a Facility Nama (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		Town, or Location of Death	h 4c. County of Dee		
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. lest birthdey) 1 MC 65 Yrs.		der 24 Hrs. 8. Dete of Bir	rth 9. Bir	thplece (State or Fore ountry) rginia	
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Physician /Medical	23e. Pert1. Enter the disease, or complications that curised the death. Do not anter the shock, or heart feilure. List only one cause on each line.	Snow Hil.	eral Home Prologo Branch Home Prologo Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch Branch	oury, MD 21		
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State Registrar	31. Data filed (Month Day, Year) JUN 2 1 2000 32. Aggistrar's Signetura	parks				

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30TH Month Year LAWRENCE M. WILLIAMS, ST. 2000 2:00 PM JUNE 4b. City, Town, or Location of Daath 4a Facility Name (If not Institution, give street and number) 4c. County of Death PANDALLS TOWN BALTIMORE HOSPITAL CENTER NORTHWEST If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 17, 1929 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Months Days Hours 1⊠M 2□ F Yrs 219-22-7602 70 Maryland Usual Residence of Decedent 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 20 No Maryland Baltimore Windsor Mill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6914 Dogwood Rd. 21244 United States 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1⊠Yes 2□No1945-49 If Yes, Give Year or Dates: Korea 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 □ Divorcad white 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Weapons- Guided Systems Field Engineer 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Roland Rutledge Williams Mazie Margaret Staylor 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 21244 Sheryl Campson / PR 6914 Dogwood Rd. Windsor Mill, MD. 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 1 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 2000 Metro Crematory Catonsville, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses m010 22 Name and Address of Facility Harry H. Witzke's Family Funeral Home, Inc. 4112 Old Columbia Pike Ellicott City, MD. 21043 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) ORONARY ARTERY PUSEASE Dua to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury Due to (or as a consequence of): that initiated events resulting in deeth) Lest Dua to (or es a consequança of) Part II. Other atgniftcant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown · AIN OWNIAH 24b. Were autopsy findings aveilable prior to completion of causa of death? 24a. Was an autopsy DISEASE RULMONARY OBSTRUCTIVE 2210 1 ☐ Yes 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) Other: 4☐ Nursing Home 5☐ Residence 6☐ Other (Specify) ER/Outpatient 3 DOA

Physician /Medicai Examiner

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Introductant: If flem 27 is marked other than "naturel, or its any Injury or other traumatic event, me the literal Examins

altimore, Maryland 21215-0020

Directo

Funeral

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death v

physician and 88 anding l id be detached for this certificate has Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice

The law requires that the death certificate be axecuted

P.O. Box 68760,

Records,

Division of Vital

Examiner Physician/Medical þ Completed Be 1º funeral Certification: a Euneral Director: Af bletely filled in by the fu

CHRONIC

25. Was case referred to medical		
examiner?	Hospital:	
1 ☐ Yes 2 ☑ No	Hospital:	2

27. Manner of Death

1 Natural 2 Accident

3 Sulcide

29a. Certifier

4 ☐ Homicide

5 Pending invastigation

28a. Date of Injury (Month, Dey Year) 6 Could not be 28e. Place of injury - At home, ferm, street, factory, offica building, etc. (Specify)

28b. Time of Injury

28c. Injury at Work? 1 ☐ Yes 2 ☐ No

28d. Describe how Injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, Stete) Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and 164

29c. License number D 42723 29d. Data signad (Month, Day, Year)

JUNE 30 TH 2000

30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) HARISH VY ERAHALL

RAMPALLSTOWN AND 21133 ,

State

edical

31. Date filed (Month, Day, Year)

0 5 2000

32. Registrar's Signature

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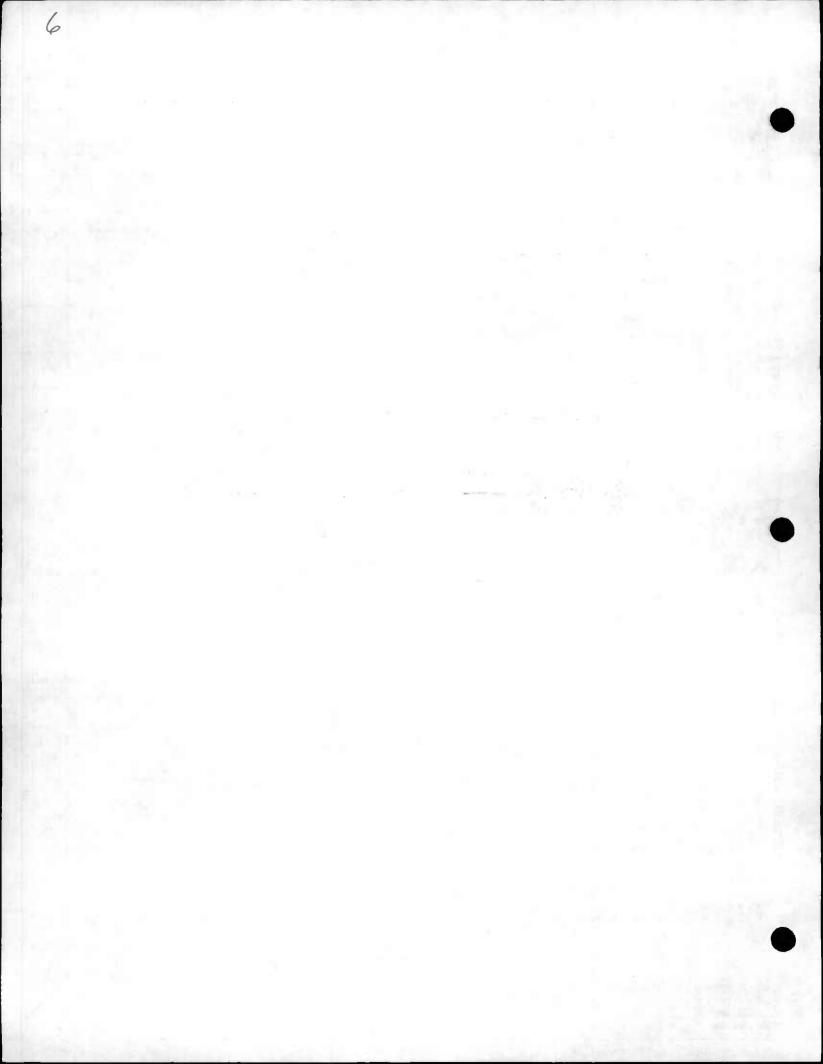
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day Year **Physician** ROY HOBERT WILSON 30_ 2000 JUNE 7:29 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SOUTHERN MARYLAND HOSPITAL CENTER CLINTON If Under 24 Hrs. 8 PRINCE GEORGE'S 5. Social Security Number Birthplaca (Stata or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Months 1 M 2□ F Days Hours Director 218-12-9829 78 FEB 12 1922 Kentucky death with the Maryland 10a. State 10c. City, Town or Location 10d. tnside City Limits worle Maryland Prince George's ma 23a or 28a-f short 1 ☐ Yes 2 No Director Brandywine t0e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Nerna 23a Funeral 16204 McKendree Road 20613 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No If #es, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, atc. 11. Marital Status permit. Pages 1 and 2 should be liked within 72 hours effer c. Department of Health and Mental Hyglens. Important: If item 27 is marked other then "natural", or han any injury or other treumatic avant, the Medical Examinations. 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 9 Carpenter Construction Baltlmore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumame) John F. Wilson Ruth Goodin Wilson 19a. tnformant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Edmund I. Beyer (step son) 11618 Kipling Drive Waldorf, MD 20601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 17 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Trinity Mem. Gardens 7+7-00 Waldorf, MD 5 Other (Specify) ot 21. Signatur 22. Nama and Address of Facility M00173 Eberwein Funeral Service 4433 White Pls La White Pls., MD 20695 con 23a. Part Lenter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and the death of the death. Approximata tntarval Between Onset and Death Physician /Medical tmmediata Cause (Finat disease or condition resulting in death) 2 was SEPSIS Examiner Due to (or as a consequence of): 2 4000. Physician/Medical Examiner oumiess gangrene ed by the ettending physician and deteched for use as the burlai-fransit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of death? been signed by I should be detect 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Corunam A.d3 Division of Vital Records. à Be Completed 24b. Were autopsy findings available prior to 24a. Was an autoosy completion of cause of death? this certificate has 1 Yes 20 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director; p 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Conpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? t ONaturat 5 Pending 1 Yes 2 No investigation 2 Accident 8 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical ck only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7-1-00 D46478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sureph Surratts Rd A 307. Clinton mD 20735 A. Pateling 7501 32. Registrar's Signature 31. Date filed (Month, Day, Year) State ooks JUL 0 3 2000

DHMH 16 Ray 6/95

Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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			Cei	tificate of	Death		Reg. No.		ru (" ()
1. Dec	edent's Name (First, Middle, La	ist)			400 H	2. Dete of Month	Dealh Dev	Year	3. Time of Death
an W	ELLING-TO	NO. U	DARD,	JR.		June	0000	700	2:30 PM
Cai	ility Neme (If not institution, given				4b. City, Tow	m, or Location of De		of Deeth	
	INRISE CA	ARE FACI	CITI	1	ELL	TON	CE	CI	
5. Soci	el Security Number 6. S	Sex 7. Age (In)	rs. last birthday)	If Under 1 Year	If Under 2	4 Hrs. 8. Date of	Birth Dey, Year)	9. Birth	plece (Stete or Foreign
21	9-42-7994	10M 20F 54	Yrs.	Months Deys	Hours	Min. (Month,	24 1,1946	M A	RYLAND
Usuel	Residence of Decedent								
10a. S		100.	City, Town or Lo					1	10d. Inside City Limits
10e. Si	YLAM) CECIL		ELKTO	~					1 ☐ Yes 2 ☐ No
10e. S	reet and Number			10f. Zip Code			10g. Citizen of \	What Cou	ntry?
11. Me	5 MASON	COURT		210	721		u.	5.	A,
11. Me	ritel Status	12. Wes Decedent Ever i	n U,S. 13. \	Was Decedent of I	lispanic Orig	In? (Specify Yes or Puerto Rican, etc.)	No- 14. Rac		can Indien,
10	Never Merried 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No				Puerto Hican, etc.)		ck, White,	_
3 □	Widowed 4 □ Divorced	If Yes, Give Yeer or Detes:	-2/4	1□Yes 2ѾNo	Specify:		Specify	i. W	HITE
	15. Decedent's E	ducation	16e. Deced	ieni's Usuel Occup	etion	of modelna .	16b. Kind of B	usiness/in	dustry
Elen	(Specify only highest granter)/Secondery (0-12)	College (1-4or 5+)	life. I	dent's Usuel Occup kind of work done DO NOT use retire	d) most	DRINCIN	1		TZUV
Lion	12	College (1-401 54)	ELEN	TENTARY	SCHO	PRINCIP	- EDL	ACA	7 20~
1.00	her's Neme (First, Middle, Last				18. Mother	's Name (First, Mid	dle, Maiden Sumen	18)	
17. Fat	ELLING-TU	VO.WA	en, S	R.	MAR	24 ANN	E LAU	USO	~
19a. Ir	forment's Neme/Reletionship (Type, Print)	19b. Meilin	ng Address (Street	and Numbe	r or Rural Route Nu	nber, City or Town,	Stete, Zip	o Code)
14	INDAW. W.					aKTON		219	21
20e. M	ethod of Disposition	20	h Place of Disno	sition /Neme of		Dete	200 Location	City or T	own, Stete
	Buriel 2 Cremetion 3	Removel from State	Cometery, cren	natory or other pla-	0/6	6/29/00	11201/2	TISP	PENASYLVAN
	□ Donetion 5 □ Other (Special	(2)				-/-	W.CHES	160	704392
21. 58	neture of Funeral Service Lice	nsee	22	. Name end Addre			Furrer		
	XXXX	1		259 €	· ma	IN ST	ELK70	VI	nD Zizzi
23a. F	ert1. Enter the disease, or com hock, or hear failure. List only	plications that caused the cone cause on each line.	leeth. Do not ent	er the mode of dyir	ng, such es d	cardiac or respiretor	y errest,		Approximate Interval Between
	1	1		^					Onset and Deeth
	liete Ceuse (Finel e or condition	HSTOO	cyloma	Brain	2				Upm
resulti	ng in death)	0.	o or as a consec						10113
Seque	ntially list conditions.	b Due t	o (or es e conseq	uence of):		1.00			
if any, ceuse.	ntially list conditions, leeding to immediate Enter Underlying (Disease or Injury								
thet in	tieted events	C. Due le	o (or es e conseq	uenca of):					
resulti	ng in death) Last		-						
		d							
Pert II	Other significant conditions of	contributing to death but not	resulting in the u	nderlying cause gi	ren in Pert I	23h F	id tobacco use co	otributa t	o the causa of death?
Pert II.		on in a second of the	Todaming in the di	neonymig oacoo gi	on are on a				bably 4@Unknow
							_ 135 2LINO	٥١١٥	John View
						24e. W	es an autopsy	24b. W	ere eutopsy findings
			100	1950		P	erformed?	CC	vailable prior to empletion of cause
									deeth?
						1	Yes 2 No	1	☐ Yes 2☐ No
өха	s case referred to medical aminer?	Hospitel:		(0)		of Deeth (Check or			
	Yes 2 No	1 U Inpatient	2 ☐ ER/Outpatier	I 3LI DOA	4 MINU	rsing Home 5 R			fy)
	nner of Deeth Netural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Yea	r) 28b. Time of Injury	Wo			oe how injury occur	red	
	Accident investigation Suicide 6 Could not be			M 1 🗆	Yes 2 1				
	Homicide determined	28e. Plece of Injury - A building, etc. (Sp	N home, farm, str ecify)	eet, fectory, office		28f. Locatio	n <i>(Street and N</i> um <i>l</i> Town, Stete)	ber or Rur	el Route Number,
29e. C	ertifier 1 Certifying Ph	ysician: To the best of my niner: On the basis of exam	knowledge, deeth	occurred at the timestication in my	me, date end	pleca, end due to the	he ceuse(s) and m	enner es s	steted.
	ne)	and menner steted.	Gray Gray Or III	ougunon, in my t	pinon, uodi	Society of the life			
29b. S	gnature and title of cartifier	00	0 40	29c. Licens		22	29d. Dete signe		
	A	acheler	THO	1	233	322	June	30,	2000
30. Ne	me and address of person who	completed cause of deeth (Item 23e) (Type,						
5	S-SHEHDEV	MD, 118M	orth St	Suite 3	B. E	Elkani	10219.	21	
_								- 4	
	e filed (Month, Dey, Year)	32. Registrer's S	gneture						

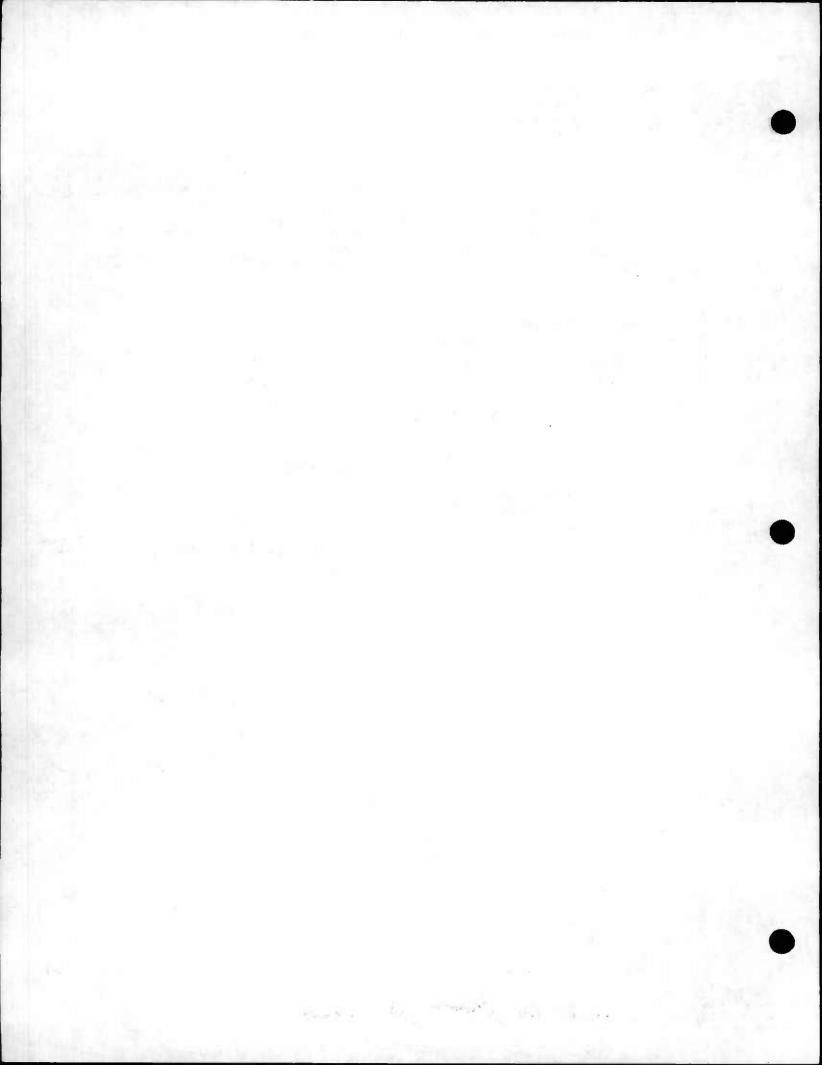
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State of Maryland / Department of Health and Mental Hygiene

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00	22	i	C	6

cian lical				Cel	unca	le UI	Death			Reg. No.		time 6 1 6 6
	1. Decedent's Name (First, Middle,	Last)							2. Date of De Month	eath Day	Year	3. Time of Death
	CLAIRE THELMA WO	DRCH							_			2:45 p.m.
	4a Facility Name (# not institution, g		ber)	3,410			4b. City, To	wn, or Lo	cation of Deat		-	
	1311 Salonica Pl	lace					Bel.	Air		Har	ford	
1	5. Social Security Number 6		. Age (In yrs.	last birthday)	if Unde	or 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir	rth ev Year)	9. Birthp	lace (State or Foreign
	213-26-0987	1□ M 2以F	71	Yrs.	WOTHER	Days	riodis	IVINI.	June 2	1929	Mary	lace (State or Foreign to) Land
	Usual Residence of Decedent		10- 0	Taura auto								0.1 1 1 0 1 1 2
-	10a. State 10b. County			y, Town or Lo	cation						1	Od. Inside City Limits
9	Maryland Harfo	ord	Fal	eston								1 ☐ Yes 2 💢 No
Director	10e. Street and Number				10f. Z	ip Code				10g. Citizen of V	Vhat Coun	try?
	2413 Reckord Roo	ad			2	1047				U.S.A		
Funeral	11. Marital Status	12. Was Deced		,S. 13.	Was Dec	edent of H	lispanic Ori	gin? (Spe	cify Yes or No Rican, etc.)	o- 14. Rac	e - Americ	
	1 Never Married 2 Married		₽ No		1 ☐ Yes		Specify:			Specify		
6	3 Widowed 4 Divorced	Year or Da	es:			-74	open,			Эреспу	Whi	te
Completed	15. Decedent's (Specify only highest)	Education grade completed)		16a. Dece	dent's Us	ual Occup	ation during mos d)	t of worki	na	16b. Kind of Bu	usiness/inc	dustry
현	Elementary/Secondary (0-12)	College (1-	4or 5+)				d)			5.707		
ဂ္ဂ	12th grade			Home	emake	ア				Own H		
Be	17. Father's Name (First, Middle, La	est)								, Maiden Suman	10)	
၉	Charles Gais						Cl	ara 1	wheite	rt		733
. [19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailie	ng Addres	s (Street	and Numbe	or Aura	l Route Numb	er, City or Town,	State, Zip	Code)
	Richard H. Worch	h, Sr. (He	usband)	2413	3 Rec	kord	Road	, F	allston	1, MD 2	1047	
	20a. Method of Disposition			lace of Dispo	sition (Na	ame of	ce)		Date	20c. Location -	City or To	wn, State
	1 X Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spe		tate	2 Air N				ns 17	/1/00	Bel Ai	r. Mo	ruland
1	21. Signature of Funeral Service Lic	censee	1								, ,,,,	200,000,000
	Bui C	10100	000		schun	unek	tune	ral	Home,	inc.	010	
	200 Posts Salvatha diagram	The same	<i>xee</i>							nore, MD	212	
	23a. Part1. Enter the disease, or co shock, or heart failure. List or	nly one cause on ea	ch line.	n. Do not em	er the mc	or ayıı	ig, such as	Cerdiac	i respiratory a	inest,		Approximate Interval Between Onset and Death
	Immediate Cause /Final				-							
	Immediate Cause (Final disease or condition resulting in death)	a	Meta	stoutio	- 5	ndo	met	ria	Can	cer		2 423
_	Todaling in dodling		Due to (d	or as a consec	quence of):					1	
Examine		b										
xar	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying		Due to (d	or as a consec	quence of):						
	Cause (Disease or injury	c										
응	that initiated events resulting in death) Last		Due to (c	r as a conseq	uence of):					i	
Medical		d.				Y 11					1	
Physician	Part II. Other significant conditions	contributing to dea	th but not res	ulting In the u	ndertying	ceuse giv	en in Part I		23b. Did	tobacco use co	ntribute to	the cause of death?
c									1 🗆	Yee 2 No	3 Pro	bebly 4 Unknown
0												
þ									24a. Was perf	s an autopsy ormed?	av	ere autopsy findings ailable prior to
2								_				mpletion of cause death?
2											10	Yes 21 No
Š									10	Yes 2 No		
Completed by	25. Was case referred to medical						26. Piace	of Deat				243110
o Be Completed by	examiner?	Hospital:	nationt 2	ER/Outnetier	nt a∏ [OA OII	oer.		(Check only	one)		Daughter'
to be completed by		28a. Date o	Injury	ER/Outpatier		AUA	ner: 4□ Nu	ırsing Ho	me 5 Res	one)	er (Specif	Daughter'
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Medical Certification: To Be Completed by	examiner? 1	28a. Date or (Month) to be led 28e. Place of buildin Physician: To the becaminer: On the becaminer and manning the completed cause	Injury Day Year) of Injury - At h g, etc. (Special pest of my kno sis of examina er stated.	28b. Time o injury ome, farm, str y) wledge, deatt tion and/or in	M M reet, factor h occurre vestigation 2	28c. Injury 28c. Injury 29c. Injury ory, office d at the tirn, in my c	ner: 4 Nu Nu Nu Nu Nu Nu Nu Nu Nu Nu Nu Nu Nu	No No No	me 5 S Res 28d. Describe 28f. Location City or To	one) idence 6 COth how injury occur (Street and Numb iwn, State) cause(s) and me date and place,	per or Rura anner as s and due to d (Month,	Daughter's residence at Route Number, lated. Day, Year)



Please Type or Print In Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day July 10 2000 **Physician** 8:26 AM Mavis Waterman /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Anne Arundel Medical Center Anne Arundel Annapolis If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days 1 M 20 F 82 February 2, 1918 New Zeland Director 054 28 3009 10a. Slate 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla Yes 2□No Director Maryland Anne Arundel Annapolis 28a-f s 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be r 1004 Sand Piper Lane 21403 United States Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No 8 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White ģ If Yes, Give Year or Dales: 3 ₩idowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Own Home Homemaker 12 18. Molher's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be James Gunn Ivy Murch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) . 1004 Sand Piper Lane Annapolis, MD Department of Health a important: If item 27 is any injury or other tra Paula Gunn Waterman/ Daugter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place)
o. Wash. University 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State July 10 Washington, D.C. 4 Donation 5 ☐ Other (Specify) Medical Center Signature of Funeral Service Licenses 22. Name and Address of Facility Columbia Mortuary Services, Inc. P.O. Box 58007 Washington, D.C. 20037 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsel and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical silated cardiomyop months Examiner Due to (or as a consequence of) Examine Coro wary arts

Due to (or as a consequenca of): ician and bunal-transit The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760, physician the buna Physician/Medical that initialed events resulting in death) Last Due to (or as a consequence of): P.O. 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. failure 1 Yes 2 No 3 Probably Wunknown Division of Vital Records. þ Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Stroke completion of cause of death? eged 1 Yes 1 Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) 1 Yes 20 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Inpatient Medical Certification: To 2 ER/Oulpatien 3 DOA After this 27. Manner of Death
1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No death. Director: 6 ☐ Could not be 28f. Localion (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) efter 4 Homicide To the Hospital or within 24 hours eff To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the lime, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the lime, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of cartified 50023146 MI address of person who completed cause of death (Item 23a) (Type, Print)

Registrar **DHMH 16 Rev 6/95**

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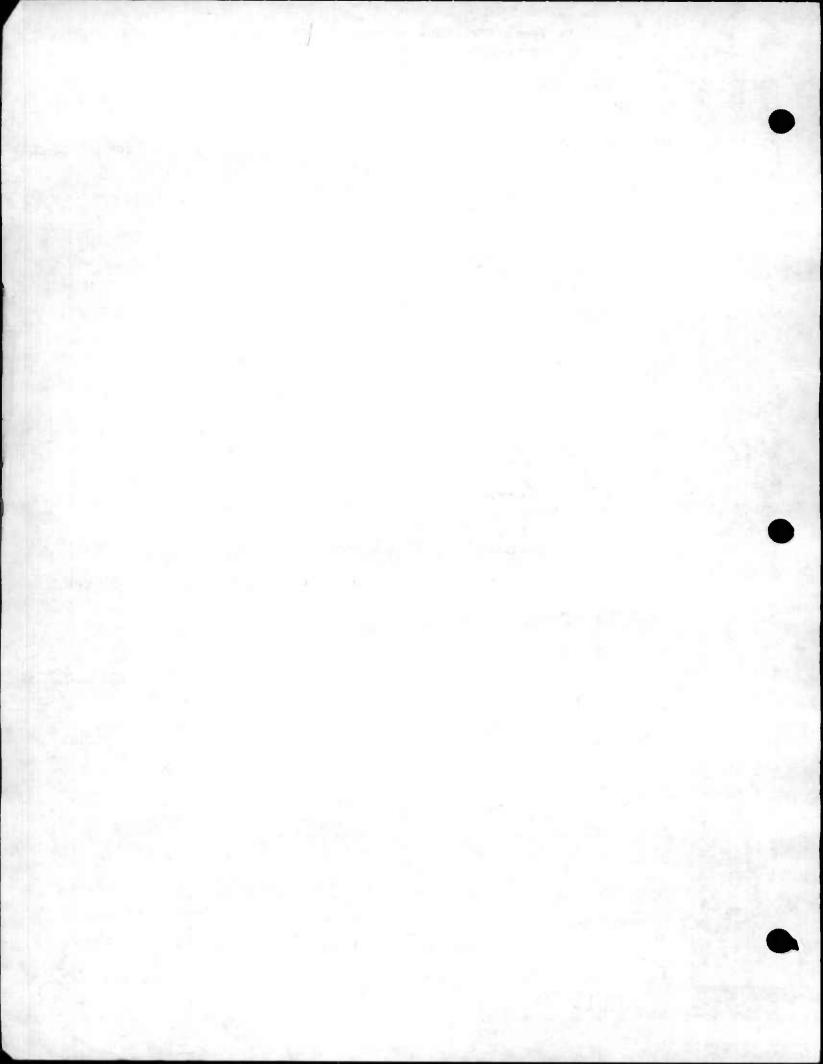
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31. Date filed (Month, Day, Year) 2000

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32. Registrar's Signature

Mitchellville



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22154

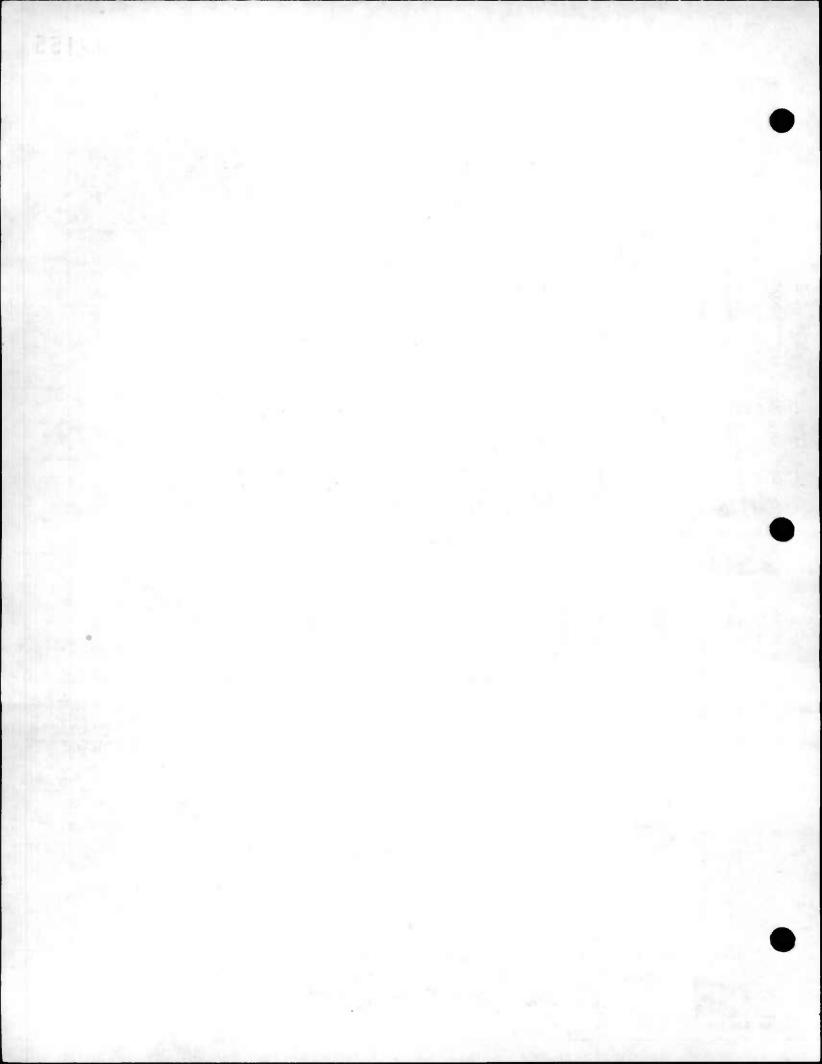
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		9a. Informant's Name/Relation									ber, City or Town,			
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State of Maryland / Department of Health and Mental Hygiene 10

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physician and as the burial-transit edical Examir	Sequentially list conditions, if any, teeding to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events	c		Due to (or es e c									
oding se se	resulting in death) Lest	d										•	
d by the etten letached for u Physician	Pert II. Other significant cond	tions contributin	ng to death bu	t not resulting in	the under	tying cause gi	iven in Pert I.	9	23b. Did	d tobacco use contribute to the cause of de			
igned by the etter be detached for i by Physicial									10	Yes 2□No	3 Pr	obably 4X Unkr	
been sign should be leted b										s en eutopsy ormed?	8	Vere autopsy findin veilable prior to ompletion of cause f death?	
pege 2									10	Yes 27 No	1	☐ Yas 2☐ No	
certificate rector, per	25. Wes case referred to medi	cet					26 Place	of Deat	h (Check only		1		
	examiner? 1 ☐ Yes 2 🗶 No	Hospite	t: 1 Inpatier	nt 2 ER/Out	tpatient 3	3 DOA O	hor			idence 6 XIOtt	er /Sner	ity) HOSPIC	
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within 24 hours after To the Funeral Dir completely filled in Medical Cert	29a. Cartifiar 1X Certification (Check only one) 2 Medic	al Examiner: Or	To the best of the basis of a menner stell	axaminetion and	, death occ	curred at the t igation, in my	ima, data and opinion, death	place,	and dua to the red at tha tima	cause(s) and m , data and place,	anner as and dua	stated. to the ceuse(s)	
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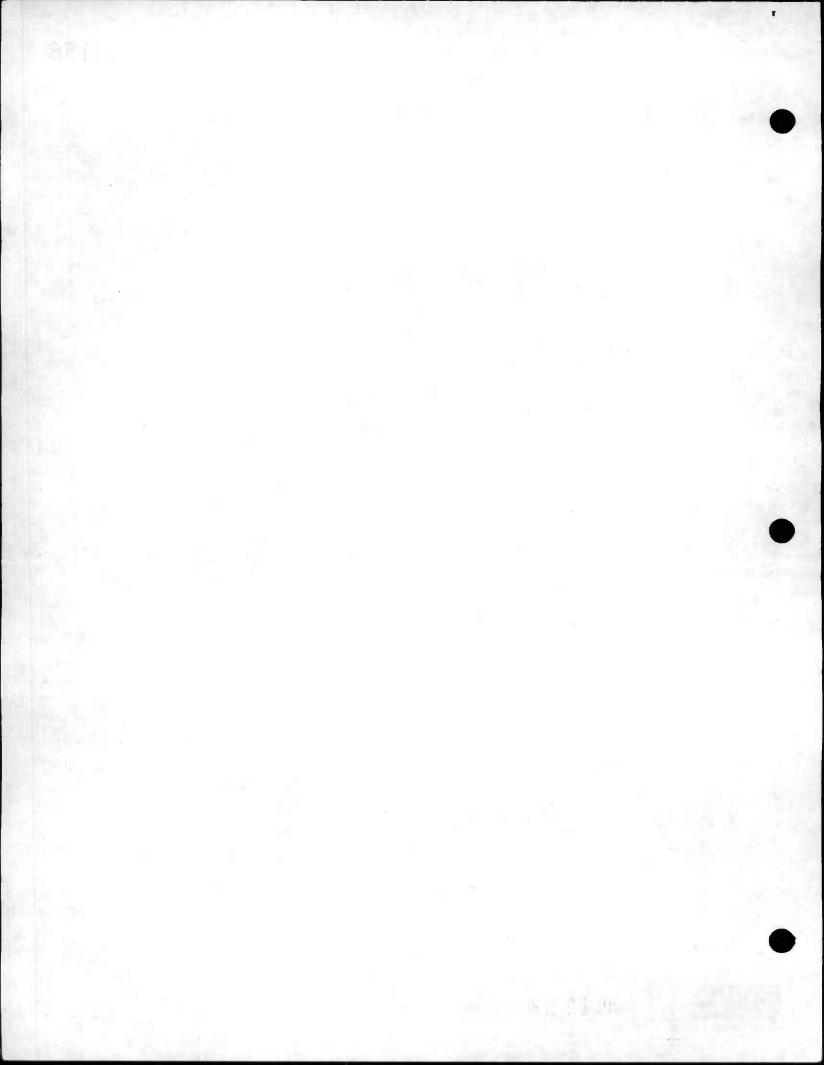
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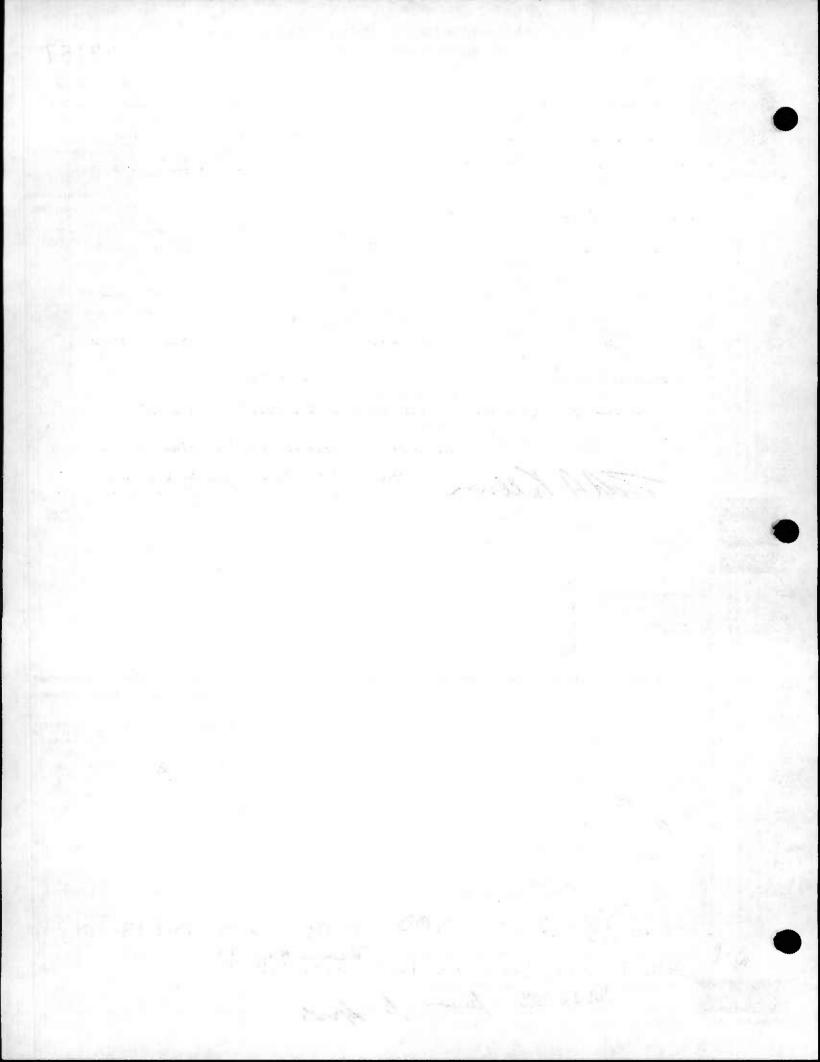
State of Maryland / Department of Health and Mental Hygiene 0 0 22 | 56

ysician	1. Decedent's Nama (First, Middla,	Last)			2. Date of Deeth	. No.	3. Tima of Death
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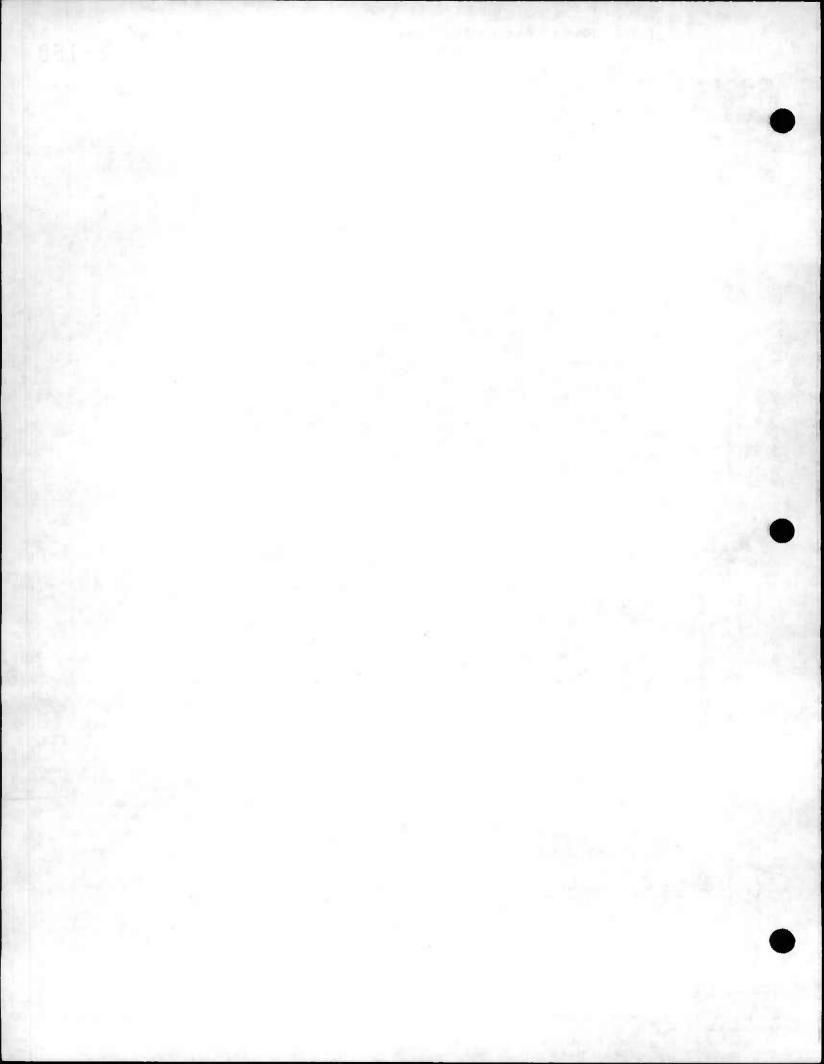
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21215-0020 of within 72 hours after death with the Maryland giena. or then "natural", or flems 23s or 28s—1 show the Medical Explanar must be notified at	by Funeral	11. Maritel Status 1 □ Never Merried 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Deceden Armed Forces 1 Yes 2 If Yes, Give Yeer or Detes	? No		Wes Deceder If Yes, specify 1 ☐ Yes 2₹			Specify Yes or N rto Rican, etc.)		Race - Americ Bleck, White, Pecify: White	etc.
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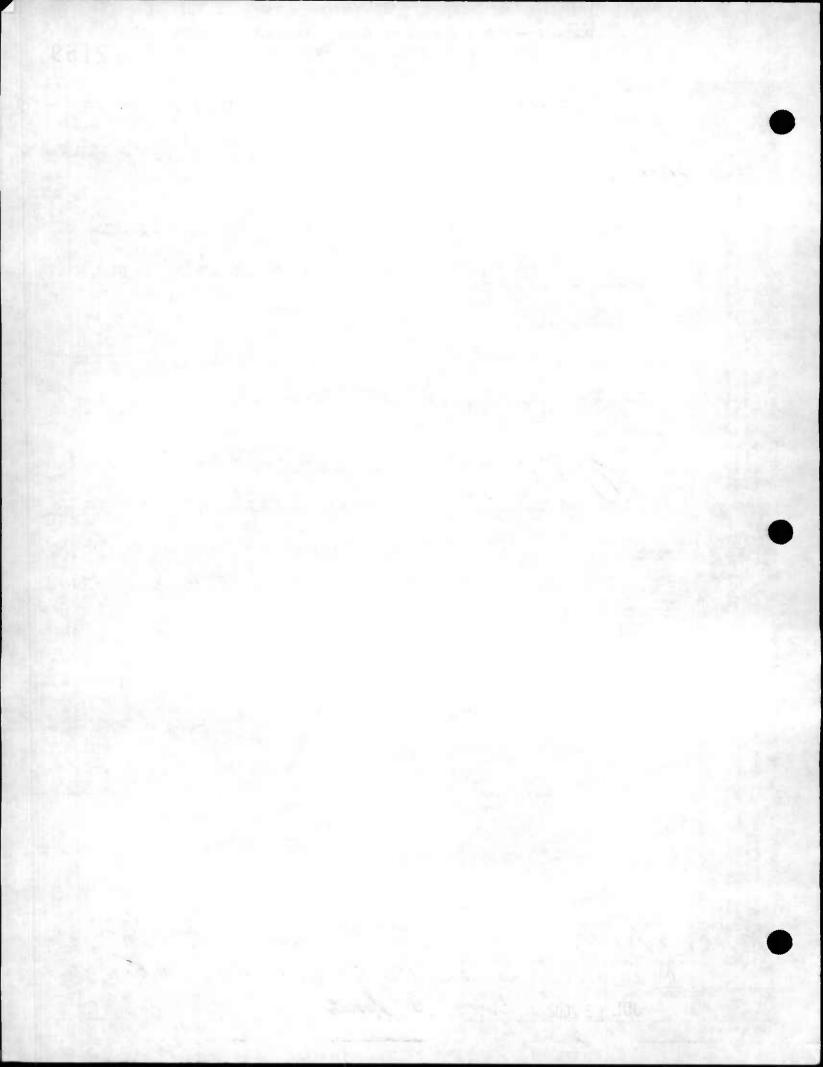
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State of Maryland / Department of Health and Mental Hygiene 00 22 1 6 0

State of Maryland / Department of Health and Mental Hygiene $\overline{\mathsf{U}}\,\mathsf{U}$ amend item 26 per phys. G785 7/13/00 yg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Day Physician JUNE 29, 2000 LIONEL M. EDWARDS 6:50 PM /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11714 Reynolds Road Kingsville Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 076-26-8284 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplece (State or Foreign Country) **Funeral** 180 M 2□ F Vrs Director May 4, 1923 NY Usual Residence of Decedent with the Marylend 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-1 show other treumstic event, the Medical Examinal must be notified at Baltimore Kingsville 1 ☐ Yes 2 No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 11714 Reynolds Road Funeral 21087 deeth USA 14. Hace - American Indian, 12. Was Decedent Ever In U,S.
Armed Forces?
1 ☒ Yes 2 ☐ No
If Yes, Give
Year or Dates: ₩₩II Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Bieck, White, etc. gemit. Pages 1 end 2 should be filed within 72 hours after a Bepertmant of Health end Mentel Hygiene. Theorem: If item 27 is merked other than "naturel", or itel any injury or other treumetic event, the Medical Examines page. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) college professor education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Gilbert M. Edwards Helene Perillon 2 19a. Informent's Nema/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Evelyn Edwards/spouse 11714 Reynolds Road Kingsville, MD 21087 20b. Place of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donetion _ 5 ☐ Other (Specify) 21. Signature of Fureral Service Licensee Ronald S., Wade, 22. Name and Address of Facility Director State Anatomy Board 655 W. Baltimore Street alleee Baltimore, MD 21201 23a. Rart1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Deeth Physician UNKNOWN fmmediate Cause (Final disease or condition resulting in death) /Medical ATHEROSCLEROTIC HEART DISEASE Exonii jer Due to (or as a consequence of): Physician/Medical Examiner HYPER TEN SION burial-transit certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that left lead eace or injury Due to (or as a consequence of) that Initiated events resulting in death) Last the Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco usa contribute to the causa of death? 1 Yss 1 No 3 Probably 4 Unknown SCLEROSIS MULTIPLE signed to Records, p 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes an autopsy performed? Completed CROHN'S DISEASE 1 Yes 2 No 1 ☐ Yes Division of Vital Mospital or Attending Physician;
24 hours after death.
 Funeral Director: After this certifice Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ► FR/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 funeral 27. Manner of Death 28c. Injury et Work? 28e. Dete of fnjury (Month, Day Year) Certification: 28b. Time of 28d. Describe how Injury occurred 5 Pending Investigation 1 Netural 1 Yes 2 No 2 Accident 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and piace, end due to the cause(s) and manner stated. edicai 29a. Certifier To the Hosp within 24 hor To the Fune completely fi 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier Parshall M.D. 04000 00 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) ,9105 FRANKLIN SQUARE DR., BALTIMORE, MD. 21237 PARSHALL 31. Date filed (Month, Day, Year) State JUL 1 3 2000 Registrar

1 2 /2 - 1 TEXAL ON LENGTH IN COMMENT TO THE CONTROL MAD AND THE

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Year 1602 Catherine Alieene Fuchs JUL 2000 4b. City Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death ALTIMORE N/A AGNES HOSPITAL H Undar 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number If Undar 1 Year Birthplace (Stata or Foraign Country) 7. Aga (In yrs. last birthday) Months Days Hours 1□ M 2♥ F 215-09-2439 90 Yrs. 23, 1909 Maryland Uaual Residence of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 X No MD Baltimore Relay 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? 21227 518 Gun Road USA Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marifal Status I □ Yas 2 □ No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 1 ☐ Yas 2 ☐ No Specify: Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highast grada complated) 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) College (1-4or 5+) 12 Accounting Accounts Clerk 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Henry Fuchs Anna Talbott 19a. Informant'a Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Linda J. Dixon - neice 518 Gun Road, Relay, Maryland 21227 20a, Mathod of Disposition 20b. Place of Disposition (Name of cematary, cramatory or other place) 20c. Location - City or Town, Stata Data 7/12/00 1 XBurial 2 Cramation 3 Ramoval from Stata Elkridge, Md. 4 ☐ Donation 5 ☐ Othar (Specify) Meadowridge Mem. Park 21. Signatura of Funaral Sarvice Licensee 22. Nama and Addrass of Facility Gary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 7250 Washington Blvd., Elkridge, Md. 21075 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, abock, or heart failure. List only one cause on each line. Immediata Causa (Final disaaaa or condition rasulting in death) DOX Sequentially list conditions, if any, laading to Immadiate ceusa. Entar Underlying Cause (Disease or Injury that initiated avants resulting in death) Last Due to (or as a consequance of): NoumonsA Dua to (or as a consaquanca of): Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Nonknown 24a. Was an autopsy parformed? 24b. Wara autopay findings available prior to completion of cause of daath? 2 No 1 ☐ Yas 2 ☐ No 1 ☐ Yas 25. Waa cesa rafarred to medicel axaminar? 26. Piace of Death (Chack only ona) Hospital: Othar: 4☐ Nursing Homa 5☐ Rasidance 6☐ Othar (Specify) 2 DING 1 Yas 1 Impatiant 2 ER/Outpatienf 3 DOA

The lew requires that the death certificate be executed for use as page 2 should

After this certificate has death. the after death To the Hospital or A within 24 hours after To the Funeral Direc completely filled in by

Physician

/Medical

Examiner

Director

Funeral

P

Completed

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Examiner

Physician/Medical

Completed by

Be

27. Manner of Death

1 DNatural

2 Accidant

3 ☐ Suicide

29a. Cartifiar (Check only one)

4 Homicida

29b. Signatura and titla of certifian

5 Pending Invastigation

6 ☐ Could not be datarmined

Medical Certification: To

Funeral

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Department of P Important: If the any Injury or of

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DHMH 16 Rev 6/95

30. Nama and addrasa of parson who completed causa of death (Item 23a) (Type, Print) 6 4250N

29c. Licansa number

1 ☐ Yas 2 ☐ No

28c. Injury at Work?

1 Senifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Data signed (Month, Day, Year)

28f. Location (Street and Number or Rural Routa Number, City or Town, Stata)

28d. Describe how injury occurred

ST. AGNOS HOS PITAL, 900 CATON AVE. 21229

XANX Registrar's Signature

28a. Data of Injury (Month, Day Year)

er

28b. Tima of injury

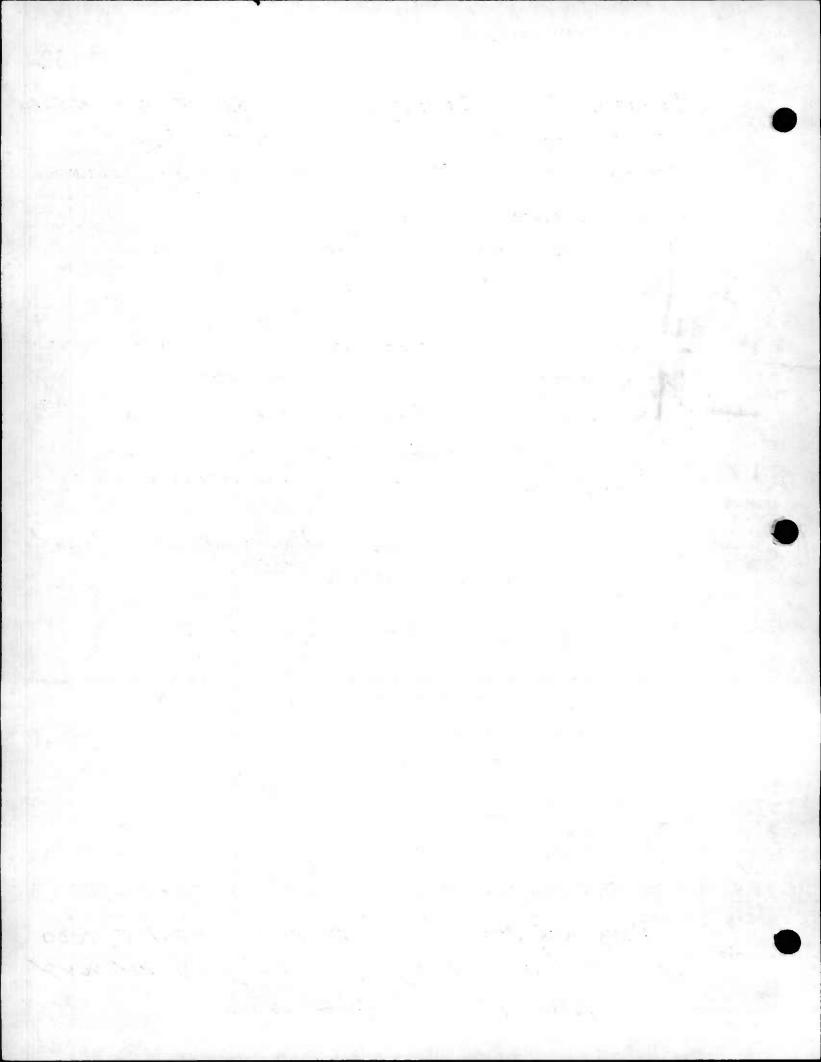
28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify)

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death Reg. No. 1. Decedant's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Death **Physician** Gringa one 2000 12:52 AN u /Medical 4e. Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Baltimore Dayview HUSPITE 5. Social Security Number If Under 1 Year Months Days if Under 24 Hrs. 6 Sex 7. Age (In yrs. lest birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foraign Country) **Funeral** XXM 2□ F 55 Yrs. Director 212-42-0442 04-11-1945 MARYLAND Usuel Residence of Decedent the Maryland 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show I be notified at 1 Yes 2 No Director BALTIMORE ESSEX MARYLAND 10e. Street end Number 10f. Zip Code 10g. Citizan of Whet Country? 23a 815 BRIARHILL PLACE APT B 21221 U.S.A. the Medical Examiner must Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes ŽŒNo or Items 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Raca - American Indien, Bleck, White, etc. a filed within 72 hours after if Hygiene. other then "natural", or Ite 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes XXNo Specify: If Yes Give Specify: þ 3 Widowed 4 Divorcad Year or Detes: BLACK Completed 15. Decedent's Education (Specify only highest grede completed) 16a. Dacedent's Usuel Occupetion 16b. Kind of Business/Industry (Give kind of work done during most of working lifa. DO NOT usa ratired) Elementary/Secondary (0-12) College (1-4or 5+) EXCAVATION CONSTRUCTION 12th grade TRUCK DRIVER permit Pages 1 and 2 should be file.
Department of Heatin and Mental Hygi, Important: If tiem 27 is marked and any Injury or other transportant. 17. Fether's Neme (First, Middla, Last) Be 18. Mother's Name (First, Middle, Meidan Sumeme) BENJAMIN G GRINAGE VERA GRINAGE 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Coda) 21221 Brenda E. Grinage/Wife 815 Briarhill Place Apt B., Baltimore, Maryland 20b. Plece of Disposition (Name of camatery, cremetory or other plece) 20a. Method of Disposition Deta 20c. Location - City or Town, Stete 1 Burlal 2 □ Cremation 3 □ Ramoval from State 4 ☐ Donetion 5 ☐ Other (Specify) SHARP STREET U.M.C. 7-11-00 CHASE, MARYLAND 21. Signatury of Funeral Service Licensee 22. Name end Address of Facility WILLIAM C BROWN COMMUNITY FUNERAL HOME PA 1206 W NORTH AVENUE 23. Perf1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cardiec or respiretory errest, shock, or heer failure. List only one cause on each line. Approximete Intervel Between Onsat and Deeth **Physician** /Medical Immadieta Ceuse (Final diseese or condition rasulting in deeth) obesity hypocentilation syndrome **Examiner** Examine OSESI 2002 S19 ettending physician end for use es the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immediate causa. Enter Underlying Ceuse (Disaese or Injury thet initieted events resulting in death) Last Due to (or es e consequence of) Box 68760. Physician/Medical Due to (or as e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by heart failure 24b. Wara autopsy findings available prior to Congestive 24e. Wes en autopsy performed? completion of cause of death? VESTIVA FOVY
25. Wes case referred to medical examiner? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No of Vital Hospital or Attending Physician: Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 € ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 No this To the Hospital or Attending Physical Action 4 hours after death.

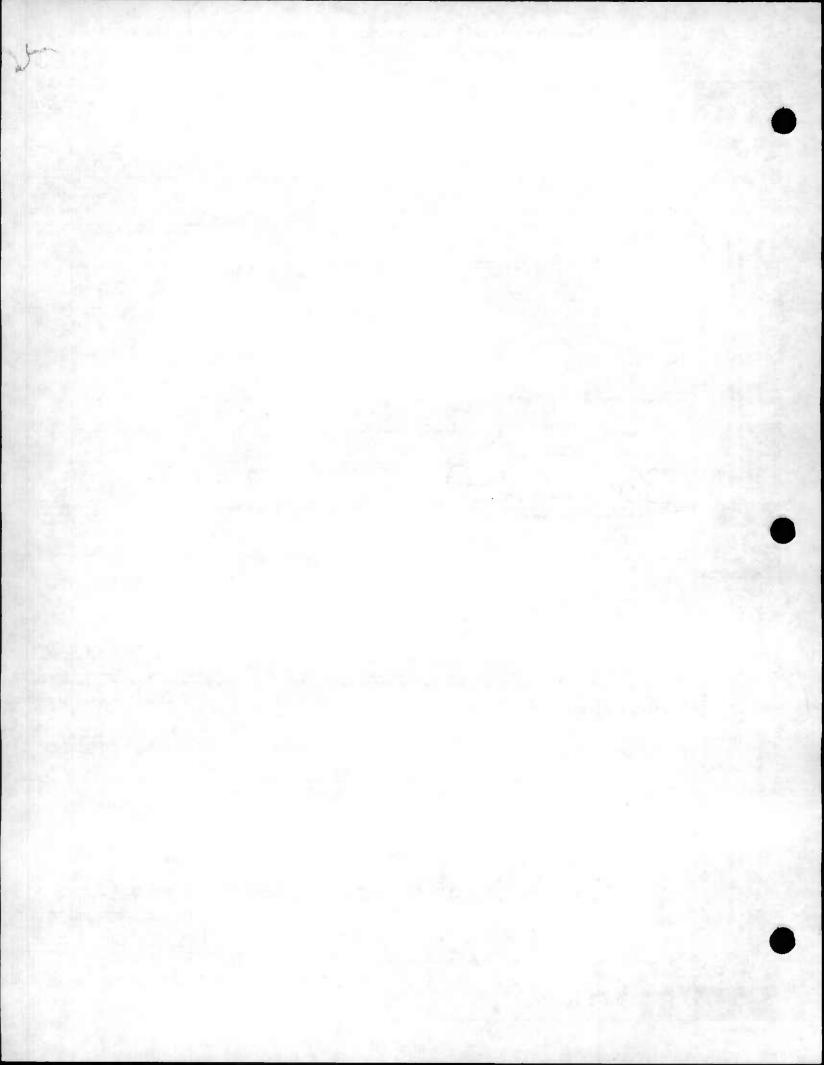
To the Funeral Ricetor: After this compilety filled in by the funeral 28a. Dete of Injury (Month, Dey Year) 28c. injury et Work? 27. Menner of Deeth Certification: 28b. Tima of 28d. Describe how injury occurred Division 1 Naturel 5 Pending investigation 1 ☐ Yas 2 ☐ No 2 Accident 6 Could not ba determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Steta) 28e. Pleca of Injury - At homa, farm, street, fectory, office building, etc. (Specify) 4 Homloida Medical 29a, Certifiar 15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, deta and place, end dua to the cause(s) end menner es steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, data and place, and due to the cause(s) end menner stated. (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Data signad (Month, Day, Year) 30. Nama and address of person who complated causa of death (Itam 23a) (Type, Print) 10805 Hickory Ridge Red Columbia Med 21049 Kazkukib 31. Dete filed (Month, Dey, Year) State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

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ene. than "natural", or items 23s or 28s-f show he Medical Examiner must be notified at ompleted by Funeral Director	10e. Street and Number 1236 Carroll St.		41	10f. Zip Code 21223		10g. Citizen of Whet Country? U.S.A.		
	11. Meritel Stetus 1 Never Merried 2 Merried 3 W Widowed 4 Divorced	12. Wes Decedent Ever Armed Forces? 1 Yes 2X No If Yes, Give Yeer or Detes:	in U,S. 13.	Was Decedent of H If Yes, specify Cube 1 ☐ Yes 2 ☐ No		Specify Yes or Norto Rican, etc.)	14. Race Bleck Specify:	American Indien, White, etc. White
	15. Decedent's Ed (Specify only highest grad Elementery/Secondary (0-12)		(Give	dent's Usual Occup a kind of work done DO NOT use retired Les Clerk	ation duning most of w	orking	16b. Kind of Bus	
T is marked other than traumatic event, the Ma To Be Comp	17. Fether's Neme (First, Middle, Last) George Brown			18. Mother's Neme (First, Middle, Meio Mary Brown Hartle)
27 ls r trau	19e. Informent's Neme/Relationship (7 Dolores Maize, da	aughter	1236	ing Address (Street 6 Carroll		timore,	MD. 2122	3
ortant: If Nem Injury or other.	20a. Method of Disposition 12 Burial 2 Cremetion 3 4 Donetion 5 Other (Specify 21. Signature of Funeral Sergica Licen	Removel from State	cemetery, cre Iount 01:	osition (Name of metory or other please ivet Cemet	tery	7-14-00	Baltimo	
vsician	23á. Part1. Enter the disease, or comp shock, or heart failure. List only o	shu		2. Neme end Addre 2119 Hammo Arbutus, I	MD. 2122	.7		Approximate Intervet Between Onset and Death
ledical aminer	Immediate Cause (Finel disease or condition resulting in deeth)	a. BRAIN Due	An eur					1
anding physician and use as the bunal-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest							
ed by the attendir deteched for use Physician/P	Part It. Other significant conditions co	ntributing to death but no	ing to death but not resulting in the underlying cause given in Pert I.				23b. Did tobacco use contribute to the cause	
2 should be d pleted by	Respinations	tarlurie				24a. Wes	s an eutopsy ormed?	24b. Were autopsy finding evailable prior to completion of cause of death?
certificate he rector, page	25. Wes case referred to medical				26. Plece of D		Yes 2 No	1 ☐ Yes 2 ☐ No
frer this uneral di	exeminer? 1 Yes 2 No 27. Menner of Death Neturel 5 Pending	Hospitel: 1 Sumpatient 28a. Dete of tnjury (Month, Dey Yea	1 Sumpatient 2 LER/Outpatient 3 LDOA 4 LI Nursing Home 5 LJ Residence 6 LOther					
within 24 hours are locati. To the Funeral Director: After the completely filled in by the funeral Medical Certification:	2 Accident investigetion 3 Suicide 6 Could not be 4 Homicide determined	28e. Pleca of Injury - building, etc. (S)	At home, ferm, st		Yes 2 □ No	28f. Location City or To	(Street end Numbe wn, Stete)	r or Rurel Route Number,
the Funeral pletely fille	(Check only 2 Medicat Exam	sician: To the best of my lner: On the besis of exa and menner steted.	knowledge, deet ninetion end/or in	nvestigation, in my o	pinion, deeth oc	ca, end due to the curred at the time	, date end place, ar	nd due to the ceuse(s)
2 E S	29b. Signeture and title of certifier	1 CILLIA		29c. Licens	e number		29d. Dete signed	(Month, Dey, Year)
8 = 8	30. Neme and address of person who o	()40 18			1764351	2451	July	12,2000



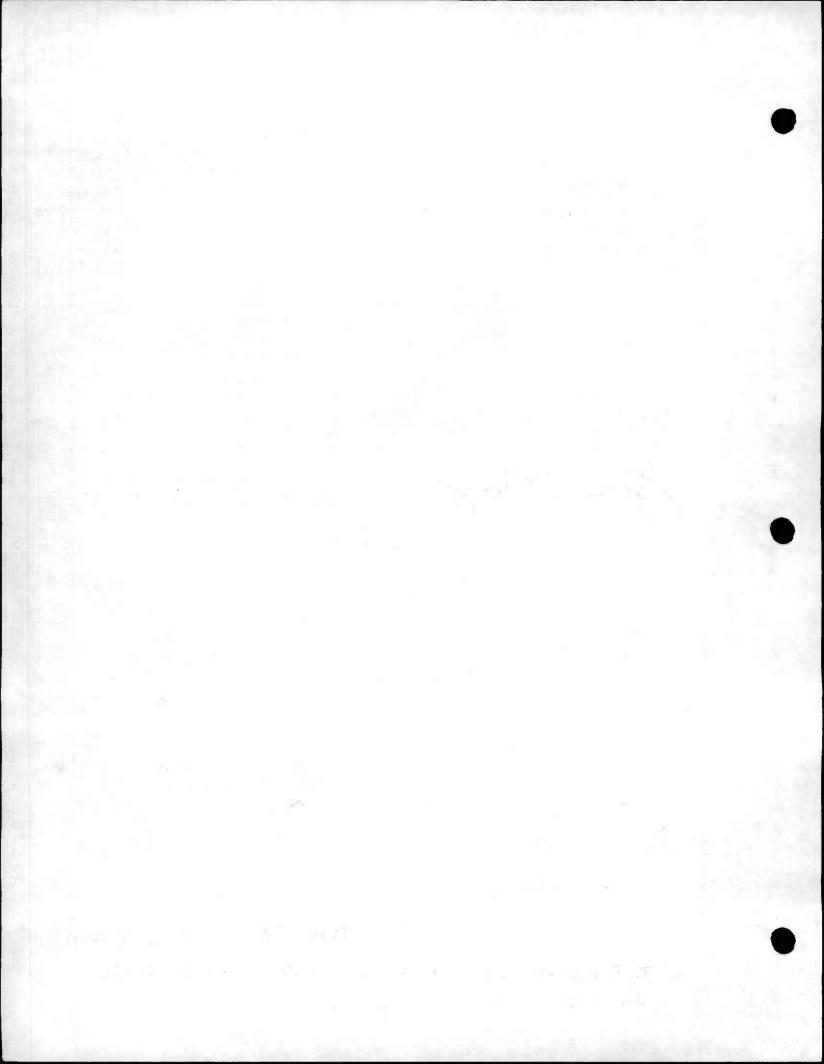
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Raymond Tyson Hatfield June 15 2000 7:05 PM /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Deaton Specialty Hospital and Home Baltimore N/A If Under 1 Yeer | If Under 24 Hrs. 5. Sociel Security Number 6 Sex 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) Aug. 26 1922 Birthplace (State or Foreign Country) **Funeral** Deys 1₩ 2□F 77 Yrs. 220-09-0520 Director Aug. Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Maryland Howard Dayton 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with Items 23a or 21036 4464 Linthicum Road United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?
1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, Whita, etc. 11. Merital Status filed within 72 hours after 1 Never Married 2 N Married Saltimore, Maryland 21215-0020 natural, or 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 7th Farmer Horse Farm permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Nem 27 is marked othe any injury or other traumatic event 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) James T. Hatfield Mary Mae Woodward 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Nancy Lee Hatfield Wife 4464 Linthicum Road Dayton, MD 21036 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☑ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Olive Cemetery 6/19/2000 Mt. Airy, Maryland all Funeral Service Licenses 22. Name end Address of Fecility Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784 23 Part1 Approximete Interval Between Onset end Deeth Inter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one cause on each line **Physician** Immediate Cause (Final diseasa or condition resulting in death) /Medical Basal Ganglia Bleed months Examiner Due to (or es e consequence of): Physician/Medical Examiner Hemiplegia months attending physician and for use as the burial-transit Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760. Sacral Decubitus month Due to (or as e consequence of): Diabetes Mellitus yrs. been signed by the a should be deteched Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy performed? s certificate has t director, page 2 s 1 Yes 2 No 1 Yes 2 No Division of Vitai director, 25. Was case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? After 1 Netural 5 Pending n 24 hours after death.

• Funeral Director: After the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the function of the functin 1 TYes 2 □ No investigation 2 Accident 6 ☐ Could not be determined 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 6 Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation in my spinior death. edical 29e. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) miner: On the basis of examinetion and/or Investigation, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end manner steted. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 11-11 D14571 30. Name and address of parson who completed cause of death (Item 23a) (Type, Print) Baltimore MD N 611 S. Charles Folkemer 32: Registrer's Signeture State

DHMH 16 Rev 6/95

Registrar



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23a, 27 PER ME G785 7/18/00 AH		rtificate of			Reg. No.						
I. Decedent's Neme (First, Middle, Last)				2. Date of De Month	Dey	3. Tima of Death					
ROBERT S. HOLTER a Facility Name (If not institution, give street and number,	4b. City, Town, or Lo	July	_	2000 07:35 A.							
					,						
Franklin Square Hospital Essex Baltimore 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) H Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or F. Country) 9. Birthplace (State or F. Country)											
212–46–3114 JSuel Residence of Decedent	55 Yrs.	Months Deys	Hours Min.	Feb.24,1	1945	Balto. City, MD					
0a. State 10b. County	10c. City, Town or L	ocation				10d. Inside City Lim					
MD Baltimore		1 □ Yes 2 0 1									
0e. Sireel and Number			10g. Citizen of V	Vhet Country?							
	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2MNo			ecify Yes or No		a - American Indien,					
1 Never Merried 2 Merried 1 Yes 2 M				Rican, etc.)	Bleck, White, etc. Specify: White						
15. Decedent's Education (Specify only highest grade completed)	(Give	s kind of work done	during most of work	ing	16b. Kind of Bu	usiness/Industry					
		el Whrker			Bethleher	Steel Co.					
	1 300	ALL VIII NO.	18. Mother's Nemo	(First, Middle,							
William P. Holter Sr.	1 - 10-		Mary Cha	mberlain	Termi						
						State, Zip Code)					
			ach Rd. Whit	-							
	complant co	osition (Name of ematory or other pla	909)	Dete	20c. Location -	City or Town, State					
4 Donetion 5 Other (Specify) St. Stephen's church Cemetery 7/10/2000 Kingsville, MD											
1. Signature of Funegal Service Rigensee	2		E.F			Home .					
23e. Pert1. Enter the disease, or complications that cause shock, or heert failure. List only one ceuse on each	ed the death. Do not en line.	iter the mode of dy	ing, such es cardlac	or respiratory e	rrest,	Approximete Interval Between Onset end Deeth					
disease or condition ATHEROSC	CLEROTIC CARDI	OVASCULAR I	DISEASE								
oodaliy w oodaly	Due to (or es e conse	quence of):									
b						1					
Sequentially list conditions, i sny, leading to immediate sause Enter Underlying	Due to (or es a conse	quence ot):									
LIGITINITIES OF STATES	Due to (or es e conse	quenca of):									
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ert II. Other significant conditions contributing to death i	but not resulting in the	underlying cause g	iven in Part I.	23b. Did	tobacco use co	ntribute to the cause of dea					
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			1137467	242 14/00	an autonou	24b. Were eutopsy finding					
						eveilable prior to completion of cause					
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					110	1 X Yes 2 No					
examiner? Hospitel:	-771 EDIO 1-11		ther			1. (01.40)					
7. Menner of Death 28a. Dete of Injury	jury 28b. Time	HIL SU DOA	ALI Nursing no								
1 Estatutal	ley Year) Injury										
3 Suicide 6 Could not be	njury - Al home, ferm, s etc. (Specify)	Ireel, fectory, office				per or Rural Route Number,					
(Check only 2 Medical Examiner: On the basis of	of examinetion end/or it										
9b. Signeture end title of certifier	0	29c. Licen	ise nu <i>m</i> ber		29d. Date signe	d (Month, Day, Year)					
VM. CE			O.C.M.E.		Jul	y 7, 2000					
0. Neme and address of periods who completed cause of	deeth (Item 23e) (Type					4					
	Armed Forces	12. 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Physician /Medical Examiner **Funeral** Director ral", or items 23s or 28s-f show Exercises must be notified at Funeral Director Johnston Completed Florence

altimore, Maryland 21215-0020 17. Fether's Neme (First, Middle, Last) Peges 1 end 2 should be nent of Health end Mental Richardson Lily T.ee 19a. Informent's Ne*me*/Reletionship (Type, Print)
Frances M. Pennell/ Daughter If Item 27 20b. Pleca of Disposition (Name of cemetery, cremetory or other plece) 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State Department Important: any Injury o 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Zama (Nardesty **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Completed by Physician/Medical Examiner Vascular Disease Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequence of) Box 68760, . Non-Healing Above Due to (or as e consequence of): P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Multiple Cerebrouascular Accident, Anemia of Vital Records. Hypothyroidism, Gastro esophagel Reflux 1 Yes 2 No Disease 25. Wes case referred to medical exeminer? Be Hospitel: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No Medical Certification: To To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? Division 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, etc. (Specify) 4 Homicide Certifying Phyeicien: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29e. Certifier 29b. Signature and title of e 29c. License number 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) D. John Sharretts State

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Deeth Johnston Florence 4b. City, Town, or Location of Deeth 10:05 000 4e Facility Name (If not institution, give street end number) 4c. County of Deeth ener If Under Balti more Square Hospital Rosed tranklin le 9. Birthplece (State or Foreign Country)
27,1915 Kansas If Under 24 Hrs. 7. Age (In yrs. lest birthdey) 85 Yrs. 8. Dete of Birth (Month, Dey, 5. Social Security Numbe 213-30-6700 Deys 1 M 2 XF Months Hours January Usuel Residence of Decedent 10a. Stele 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Baltimore Middle River 1 Yes 2 No 10e. Street and Number 10f Zin Code 10g. Citizen of Whet Country? 22 Gyro Drive 21220 United States 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bieck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritel Stetus 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 ☐ Yes 2 ☑ No Specify: Specify: White 3 Nidowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Factory Worker Box Factory 18. Mother's Neme (First, Middle, Maiden Sumeme) Jackson 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 1416 Kent Rd. Essex, MD 21221 20c. Location - City or Town, State Chesapeake Crematory, Inc. 7/12/00 Beltsville, MD CAFA Stephen D. Lohrmann P.A. 8717 Green Pastures Drive, Baltimore, MD 21286 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth 5 Days Left Knee Amputation 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24e. Wes en eutopsy performed?

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

24b. Were autopsy findings eveileble prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

26. Place of Death (Check only one)

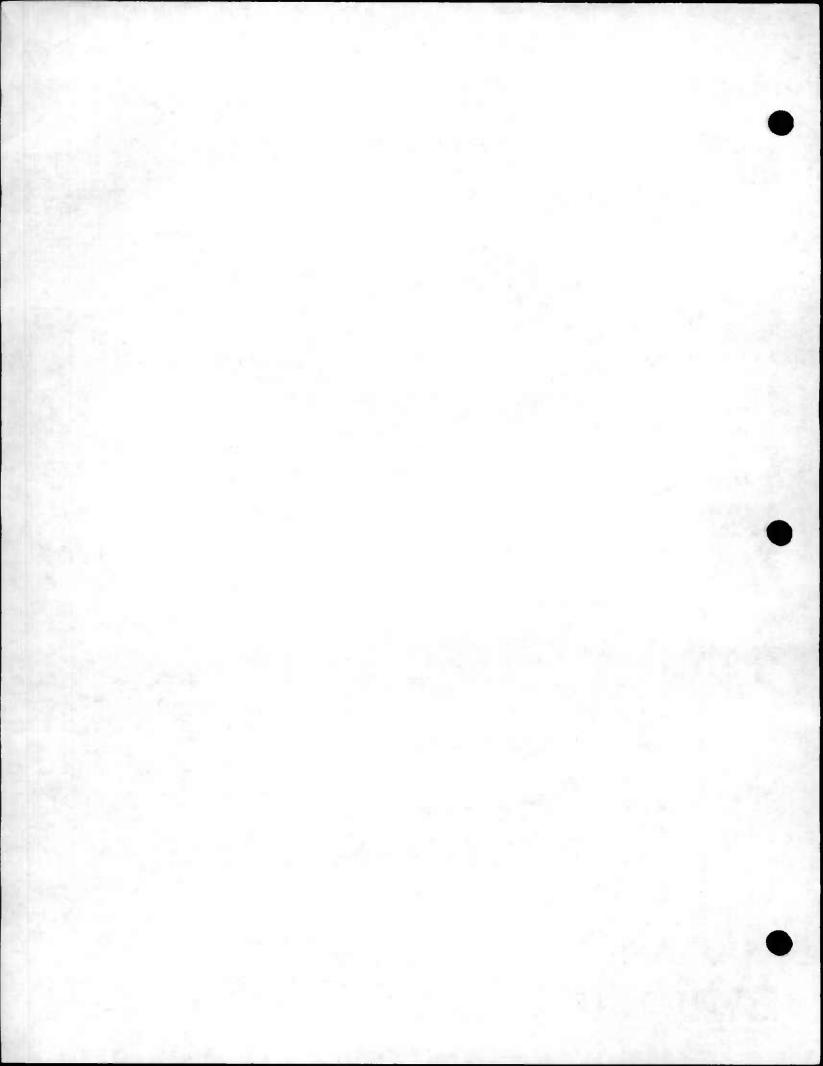
28d. Describe how injury occurred

29d. Dete signed (Month, Dey, Year)

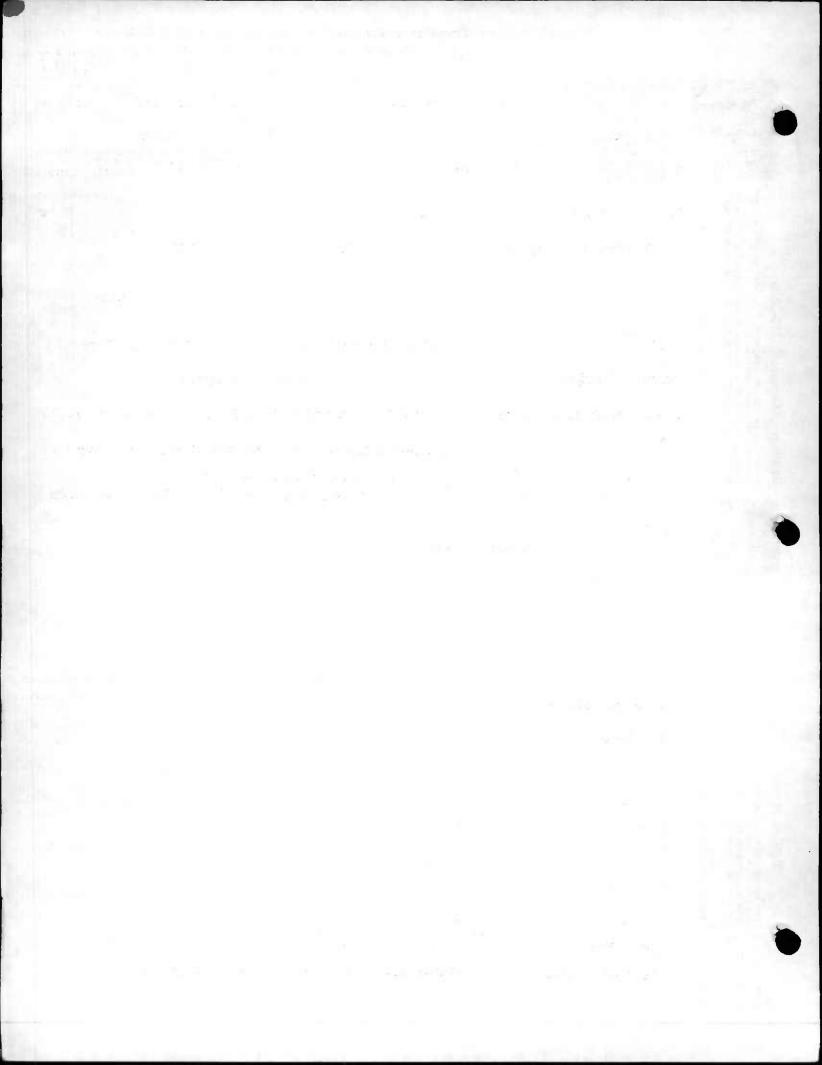
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9000 Franklin Squeire Drive Baltimore, MD 21237

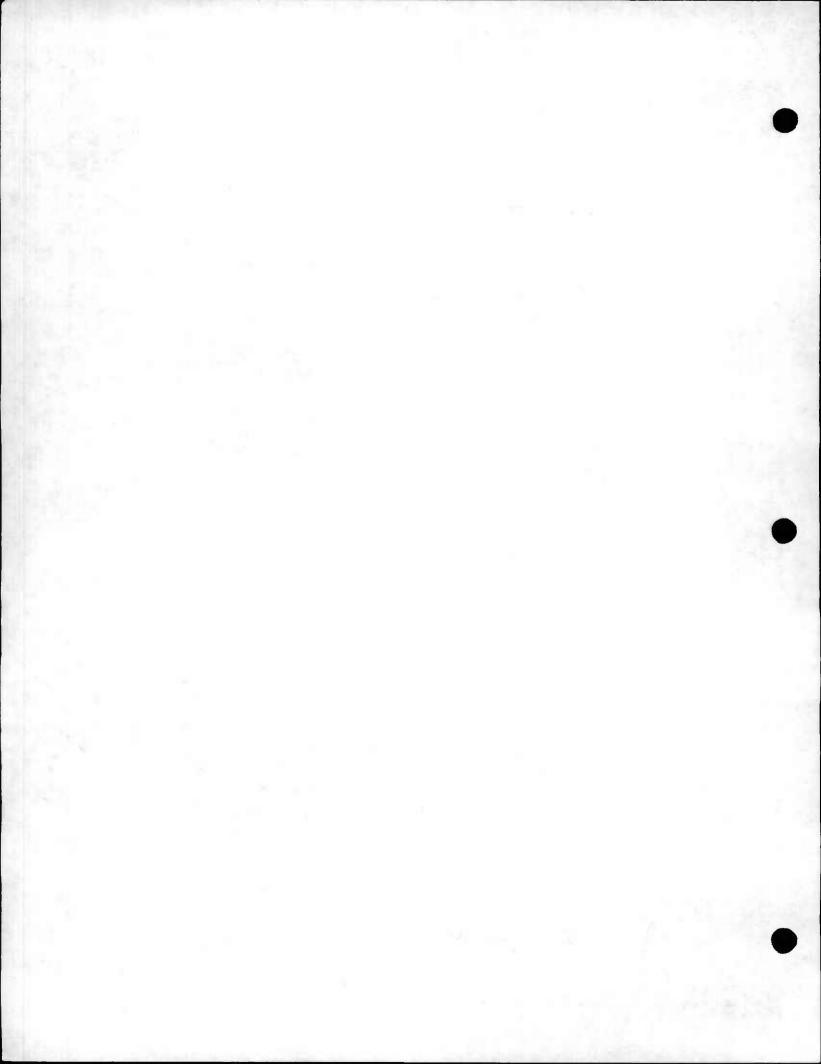
Registrar



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Physicia /Medic	al		M	edora C	ora Kro	omer		2. Date of Month Apri	11 20 ^{Da}	2000	3. Time of Death 6:50 am	
Examin	er	4a. Facility Nama (If not institution Lorien Nursing		number)			4b. City, Town, Columbi			. County of Deat Oward	h	
Funeral Director		5. Social Security Number 577–20–8506 Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☑ F		s. last birthday Yrs.	Months Days		n. 8. Date of (Month)	f Birth Day, Year) 18, 19	9. Birt Co Was	hplace (Stata or Foreign untry) hington, D	
r 28a-f show	or	10a. Stata 10b. Count MD Howar			City, Town or t	Location					10d. Insida City Limit:	
death with the Maryland ims 23e or 28e-f show	Funeral Director	10e. Street and Number 10701 Johns Ho			AL CI	10f. Zip Code 20723			10g. Cit	Izan of What Co		
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within 72 hours lene. then "natural",	Completed	15. Decada (Specify only high Elementary/Secondary (0-12)	nt's Education est grade complate College	d) o (1-4or 5+)	(Giv life.	edant's Usual Occi a kind of work don DO NOT usa ratir	e during most of v	rorking		Ind of Businass/	industry	
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 Is merked other than "naturany lipury or other traumatic event, the Medical any Injury or other traumatic event, the Medical once.	To Be Co	17. Father's Name (First, Middle, Last) 18. Mother							ddle, Maiden lgraff			
and 2 sho alth and 27 is m		19a. Informant's Name/Ralation George W. Kron		se		ling Address <i>(Stree</i>					ip Code) and 20723	
Pages 1 ament of He ant: If Item ury or other		20a. Method of Disposition 1 X Burial 2 Cremation 4 Donation 5 Other (3	3 □Removal fro	m State	cemetery, cri	Disposition (Name of place) and Veterans Cem Date 20c. Location - City or Town, Cheltenham, Ma						
Departi Departi Importu any Inj once.		21. Signature of Furreral Service Usenship MOO773 22. Name and Address of Facility Donaldson Funeral Home, 313 Talbott Ave. Laurel,									707_/389	
ficete be physicial s the bur	Medical Examiner	Immediata Cause (Final disease or condition rasulting in death) Sequentially list conditions, if any, leading to immediate causa. Entar Underlying Cause (Disease or Injury that initiated events resulting in death) Last	b. DIAB	Due to	(or as a conse	equence of):						
d by the	Physician/M	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus							Did tobacco	_	to the cause of death	
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within 2	Med	29b. Signature and this of certific	and mi	anner stated.	ml	29c. Licer	7/35		29d. Da	te signed (Monti	n, Day, Year)	
,		30. Name and addrass of person Lawrence St	vink, MD	91	05-A A	ll Saints	Road, I	aurel,	MD 20	723		
Stat Registra		31. Date filed (Month, Day, Year	0 2000	Registrar's Sig		4 /						



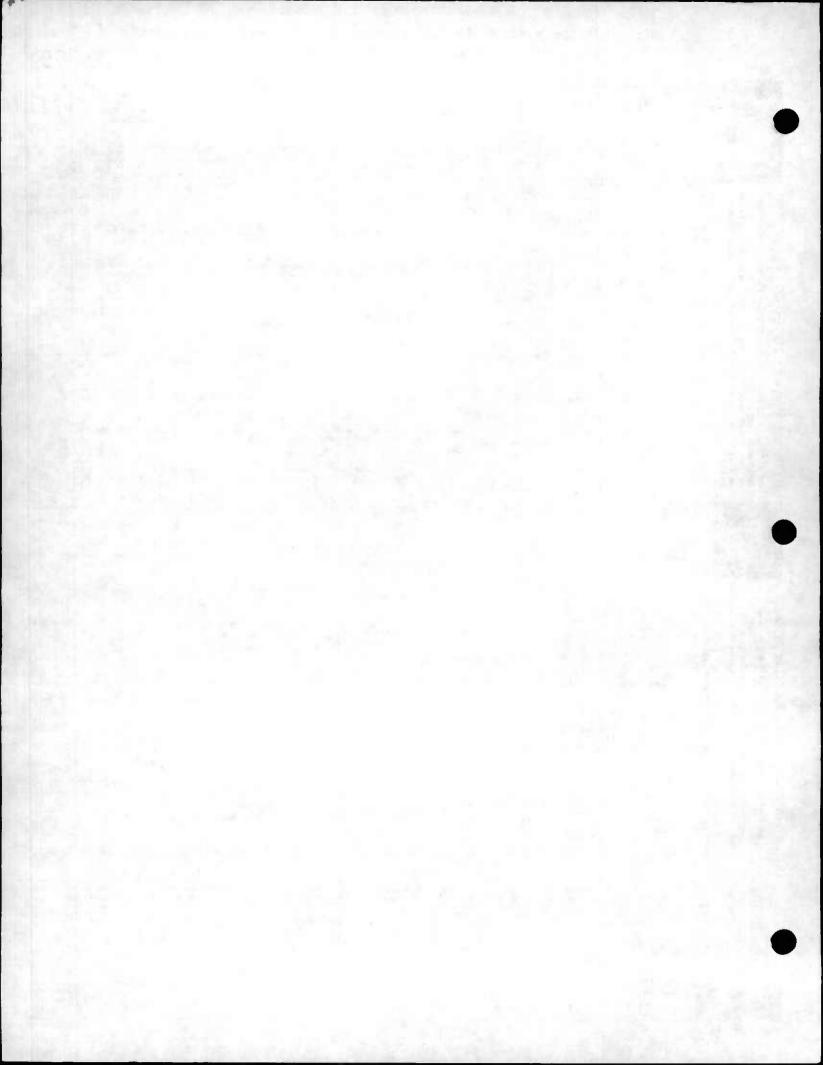
220-62-2252						2. Date of D Month	eath Day	Year	3. Time of	Death	
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	M 2 F	46 Yrs		Dayo	110010	MAY 23	, 1954	MARYL	ÄND		
Usual Residence of Decedent 10e. State 10b. County	10	Oc. City, Town or	r Location				_	100	d. Inside Ci	ity Limit	
MARYLAND BALTIMORE	CITY	BROOKLYN	I						1 ₩ Yes	2 🗆 N	
10e. Street and Number			10f. Zip	Code			10g. Citizen of V	What Country	y?		
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	M Van Chin	70_182	1 ☐ Yes	2 No	Specify:		Specify	whit	Έ		
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421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061											
Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of):											
d.											
Part II. Other significant conditions conti	ributing to death but n	not resulting in th	e underlying o	euse gir	ven in Part I.	23b. Die	tobacco use co	ntribute to t	the cause o	of deal	
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examiner?	ospital:	2 □ EB/Outos	tient 3□ DC	Otl	her:			er (Snecily)	SCE	ייוורי	
27. Manner of Death	28a. Date of Injury	28b. Tim							OCE	AND	
2 Accident Investigation	(World, Day 1	out, Injur	м								
4 ☐ Homicide determined	28e. Plece of Injury building, etc. (- At home, farm, Specify)	, street, factor	, office				ber or Rural	Route Num	ber,	
(Check only 2 Medical Examine	er: On the basis of ex	amination and/o	eath occurred r investigation	at the ti	ime, date and place opinion, death occur	and due to the	e cause(s) and m	anner as sta and due to t	ted. the cause(s	s)	
29b. Signature and the of certifier	and manner stated		290	c. Licen:	se number		29d. Date signe	d (Month, D	ay, Year)		
> Putar	ren 1	ULD		00	ME		JULY 1	L, 200	0		
30. Name and address of person who con	pleted ceuse of deat	h (Item 23a) (Ty	pe, Print)								
1 Joseph P	es tame	111	Penn S	tre	et, Balti	more, M	Maryland	21201			
	1 Never Married 2 Married 3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 17. Father's Neme (First, Middle, Last) KEVIN LOWE 19a. Informant'a Name/Relationship (Typ. HELEN P. FORNOFF / 20a. Method of Disposition 1 Burial 2 Octremation 3 Re 4 Doration 5 Corner (Specify) 21. Signature Funer Service Unerselection of the shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last 25. Wes case referred to medical examiner? 27. Manner of Death 1 XNatural 5 Pending Investigation in death) Last 27. Manner of Death 28. Certifier 1 Certifying Physic (Check only only 2 Medical Examined) 29a. Certifier 1 Certifying Physic (Check only only 2 Medical Examined) 29b. Signature and introduction of certifier.	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Making Address (Street and Number or First) (Models, Last) MACHINIST 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 19 Making Address (Street and Number or First) (Models Summand) 10 Models (Models Summand) 10 Models (Models Summand) 10 Models (Models Summand) 10 Models (Models Summand) 11 Models (Models Summand) 10 Models (Models Summand) 11 Models (Models Summand) 12 Making (Models Summand) 130 Models 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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** Soon HWa 0625 2000 /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore N/A of mi University If Under 1 Year | If Under 24 Hrs. Birthplaca (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1□M 2♥F 220-64-2411 Yrs. Director 82 JAN. 1, 1918 North Korea Usual Rasidence of Decedant 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Marylaz "natural", or items 23s or 28s-f shor 1 ☐ Yes 2√ No Director MD Howard Columbia permit. Pages 1 and 2 should be filed within 72 hours after death with the Mogarithment of Health and Mental Hydgene.
Department of Health and Mental Hydgene.
Important: if them? 72 is marked other than "natural", or items 23s or 28s⁴ stry injury or other traumette event, the Medical Examinat must be notified. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7080 Cradle Rock Way, Apt. 612 21045 USA Funeral 14. Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Maxican, Puerto Rican, etc.) 1 Yes 2 No 1 Never Married 2 Merried altimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: à Specify: Asian 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker Own Home 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Kyung Il Lee Tae Un Oh 2 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 19a. fnformant's Name/Ralationship (Type, Print) 7216 Downing Ct., Clarksville, Md. Christine H. Kelley-Granddaughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7/14/00 Meadowridge Memorial Pk. Elkridge, Md. Cary L. Kaufman Funeral Home @ Meadowridge MP, Inc. 21. Signeture of Funeral Service Licensee m SK. marshal 7250 Washington Blvd., Elkridge, Md. 23a. Part1. Enter the disesse, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory strest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in death) **Examiner** Examiner The law requires that the death certificate be executed burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaase or Injury that initiated events resulting in deeth) Lest Due to (or as a consequenca of): Box 68760. attending physician for use as the buria Physician/Medical Due to (or as a consequence of): ed by the detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. Division of Vital Records, P.O. 23b. Did tobacco use contribute to the ceuse of death? signed by 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☑ Onknown b 8 24b. Ware autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed s ueeq Hypertension certificate has 1 ☐ Yes 2 ☐ No 1 Yas 2 No or Attending Physician: 25. Was casa rafarred to madical axaminer? Be 26. Placa of Death (Check only ona) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No To this funeral 27. Menner of Desth Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After t
completely filled in by the funera 1 Natural 5 Pending Investigation 1 Yes 2 No 2 Accidant 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Placa of Injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicida To the Hospital Cortifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier edicai (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific 037818 2000 8 W 30. Neme end address of person who completed cause of death (Item 23a) (Type, Print) Nade (Jaasch University of 31. Dete filed (Month, Day, Year) 32. Registrer's Signeture State JUL 13 2000 Registrar



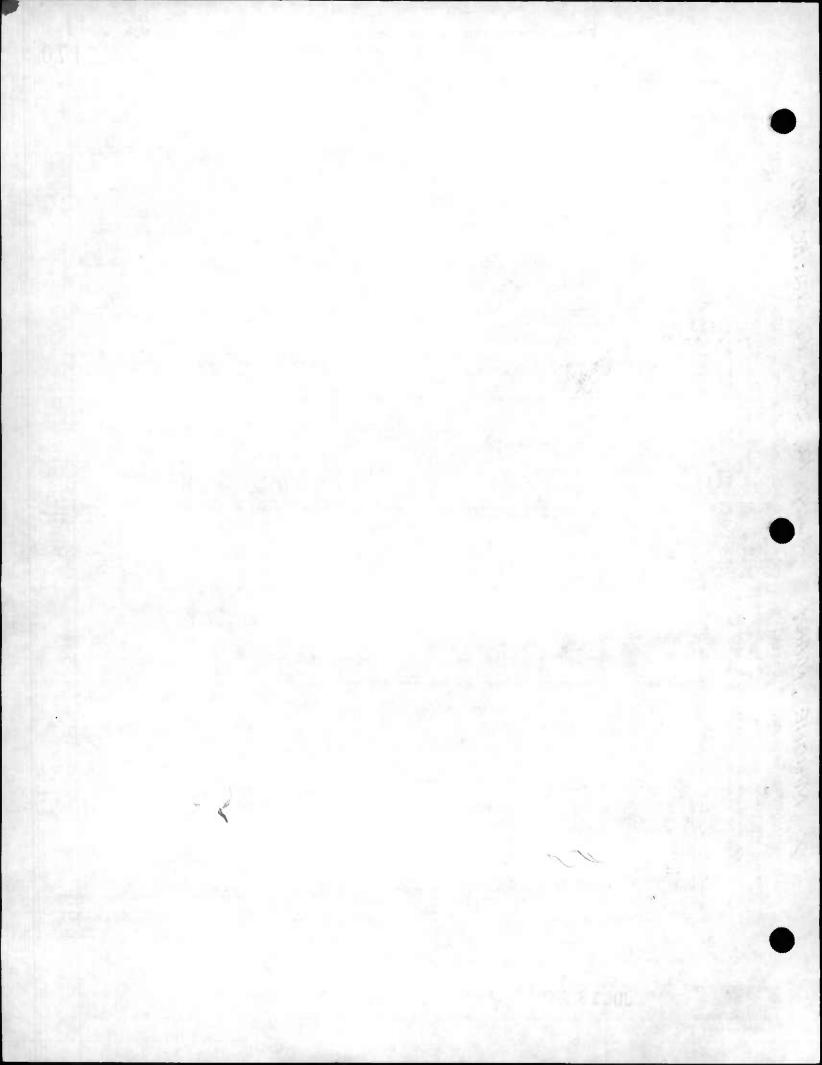
State of Maryland / Department of Health and Mental Hygiene 00 22 170

			C	ertificate of	Death	R	eg. No.	Lan. 1		
S.	Physiciar /Medica	raty condition has	ne		2. Date of Dea		3. Time of Death 12:50 AM			
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	Se-I show offised at	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimore	10c. City, Town or Lutherv					10d. inside City Limits 1 ☐ Yes 2 ☑ No		
Seath with the Marys ne 23e or 28e-f sho must be notified at neral Director		10e. Street and Number 409 Towson Avenue		10f. Zip Code 21093			og. Citizen of What C nited Stat	izen of What Country? ed States		
or after or the Examination	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates] No	13. Wes Decedent of If Yes, specify Cul		Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Whi Specify: Wr	te, etc.			
215-0020	ygiene. ner than 'neturn it, the Medical i	15. Decedent's Educetion (Specify only highest grade completed) Elemenfery/Secondary (0-12) College (1-40	(G life	ecedent's Usuaf Occu iive kind of work done le. DO NOT use retin	during most of w		16b. Kind of Business	/Industry		
	nd 2 should be filed with and 2 should be filed with and Mertals Hyglen 27 is marked other th a traumatic event, the To Be Con	Charles Eduin Schanzo	HC	omeMaker	18. Mother's N Alve	eme (First, Middle,	Own Home ddle, Maiden Sumame) List			
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more,	net: If item ary or othe	20a. Method of Disposition 1 □ Burlal 2 ②Cremation 3 □ Removat from Stat 4 □ Donation 5 □ Other (Specify)	cemetery, c	isposition (Name of crematory or other place eake Crema	tory,Inc	Date 7/13/00	20c. Location - City of Beltsville			
Bail	Departr Imports any Inje	21. Signature of Funeral Service Licensee		22 Name and Addo CAFA Step 8717 Gree	hen D. L n Pastur	ohrmann F es Drive	.A Baltimore,	MD 21286		
	hysician /Medical	23a. Part1. Enter the diseese, or complications, that caus shock, or heart failure. List only one cause on each	line.		lng, such as cerdi	ac or respiretory en	rest,	Approximefe Intervat Between Onset and Death		
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04/89 X	res trat the deeth cermicals be executed signed by the attending physician and dibe detached for use as the bufal-transit	resulting in death) Last	Due to (or as e cons							
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	within 24 hours after death. Within 24 hours after death. Completely filled in by the funeral di		jury Pay Year) 28b. Tim Injur	ry W	ury at ork? Yes 2 No	28d. Describe h	ow injury occurred			
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	B	30. Name and address of person who completed cause of	(6201,	pe, Print).	uls !	St. Ba	lts. m	121200		
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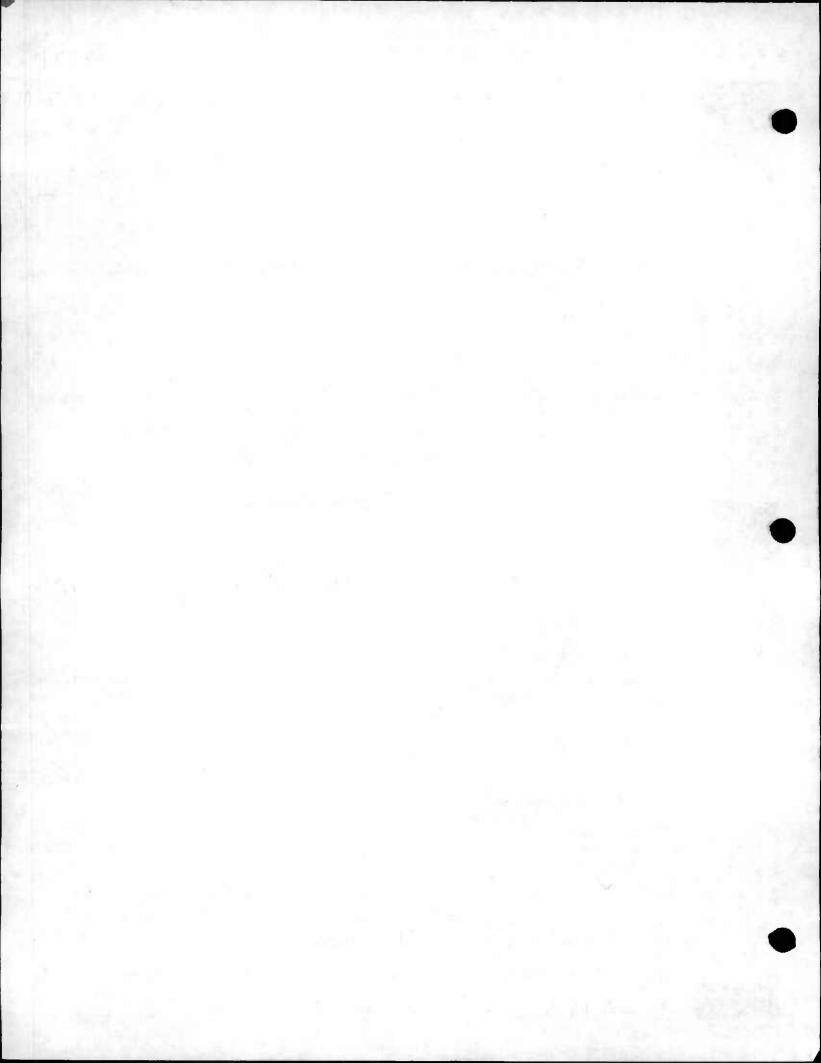
Registrar

12, 2000 @ 12:50 AM

MAIONE, MARY



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedenț'a Name (First, Middle, Last) 17h 2000 1025AM **Physician** Peter Nicholas VIUSICO JULY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore Harbor Hospital Center N/A If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) JAN. 28, 1 If Under 1 Yeer 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days 217-84-3905 39 Yrs. 1961 Director Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits with the Maryla "natural", or items 23s or 28s-f shor 1 ☐ Yes 2 No Director Maryland Anne Arundel Severn the Medical Examiner must be notifi-10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1866 Cedar Drive 21144 Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces?... 11. Meritel Stetus 1 Yes 2 Alo If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify: Specify: ğ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16h. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Mason Construction is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit ment of Health and Mental H tent: If Item 27 is marked off Be Peter Musico 2 Madeline Eleanor Rake 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 19e. informent's Name/Relationship (Type, Print) Eleanor Spradlin/sister 710 Greasy Branch Leander, KY 41228 Baltimore, 20b. Placa of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory, Inc. 7/11/00 Baltimore, MD 21. Signature of Euneral Service Licenseer Jugar 22. Name and Address of Fecility
Cremation Society of Maryland, Inc. Thomas Gregor 299 Frederick Road Baltimore. MD 21228 Approximete Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one ceuse on each line. Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Examiner Cerebro Vascula a The law requires that the deeth certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Diseese or injury that initieted events resulting in death) Last Due to (or as a consequence of) Division of Vital Records. P.O. Box 68760. ettending physician by Physician/Medical Due to (or as a consequenca of): ate has been signed by the ettending p page 2 should be detached for use as 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause Completed 24a. Was an autopsy performed? 1 Yes 1 Yes 2 No 2 - No certificate Attending Physician: 25. Wes case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 MInpatient 2 ER/Outpatient 3 DOA After this funeral 28a. Dete of Injury (Month, Dey Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 28c. injury at Work? 1 Natural 5 Pending investigation To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Af completely filled in by the fur 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be determined 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3001 S. Hanover Street, Baltimore, MD 21225 Bakleh, MD Mohanad 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar

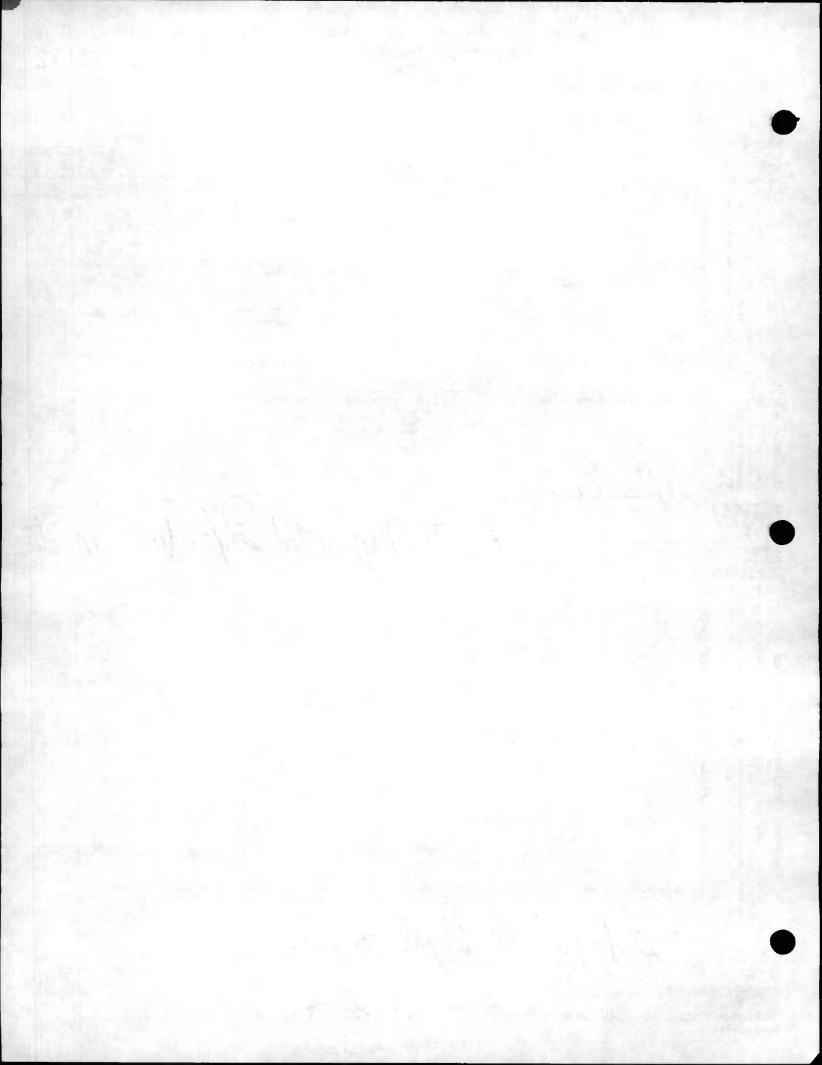


State of Maryland / Department of Health and Mental Hygiene 22172 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death JULY 10, Day 2000 **Physician** M.D. 9:30 AM LEON CLAIR PERRY /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner 2700 SUMMERVIEW WAY APT. 204 ANNAPOLIS ANNE ARUNDEL If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 6. Sex 12 M 2 F 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Dey, Year) **Funeral** 79 236-24-6932 Director MARCH 16, 1921 W. VIRGINIA **Uaual Residence of Decedent** 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits i Hygiene. other than "natural", or items 23a or 28a-f show vent, the Medical Examinar must be notified at 1 Yes 2 No Director MARYLAND ANNE ARUNDEL ANNAPOLIS 8 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2700 SUMMERVIEW WAY APT. 204 UNITED STATES 21401 Funeral 14. Race - American Indian, Black, While, etc. 13. Was Decedent of Hispanic Origin? (Spacify Yes or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 12. Was Decedent Ever in 9/52 -Armed Forces? 1942

1 Yes 2 No 1945

If Yes, Give
Year or Dates: filed within 72 hours after 1 Never Married 2 Married 1 Yes Q No Specify: Specify: WHITE Baltimore, Maryland 21215-0020 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Callege (1-4or 5+) PHYSICIAN HEALTH CARE permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if hem 27 is marked othe any lollury or other traumatic event pice. 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) 8 To MERLE WOODS ANDY PERRY 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stele, Zip Code) t9a. Informant's Name/Relationship (Type, Print) 2700 SUMMERVIEW WAY APT. 204 ANNAPOLIS, MD 21401 MRS. JEANNE PERRY/WIFE 20b. Place of Disposition (Neme of 20c. Location - City or Town, State Date 20a. Method of Disposition cemetery, cremetory or other plece)
METRO CREMATORY 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removal from State JULY 11, 2000 CATONSVILLE, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KIRKLEY ARODDICKY FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or compline ions that caused the death. Do not enter the mode of dying, such as cerdiac of many shock, or heart failure. List only on in ause on each line. Approximate Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence Examine The law requires that the death certificate be executed Sequentially list conditiona, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last attending physician and for use as the burial-tren Due to (or as a consequence of): Box 68760, Physician/Medicai Due to (or as a consequence of): Part II. Other significant conditions contributing to deeth but got result Division of Vital Records, P.O. 23b. Dtd tobacco was contributs to the cause of death? 2000 3 Probably 4 Unknown 1 Yss þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an a Completed certificate has 1 ☐ Yes 2 ☐ No 1 Yes XXNo I or Attending Physician: after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To After this 28a. Date of tnjury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 1 Netural 5 Pending Investigation 1 Yes 2 No filled in by the f 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, and due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. nd Report certifier 29d. Date signed (Month, Dev. Year) 29c. License number 29b. Signature JULY 10, 2000 60 30. Name and address of payson who completed cause of death (Item 23a) (Typa, Print) 325 HOSPITAL DRIVE GLEN BURNIE, MD 21061 HILARY T. O'HERLIHY M.D. SUITE 208 31. Date filed (Month, Dey, Year) 32. Registrar's Signature State oaks Registrar JUL 13 2000

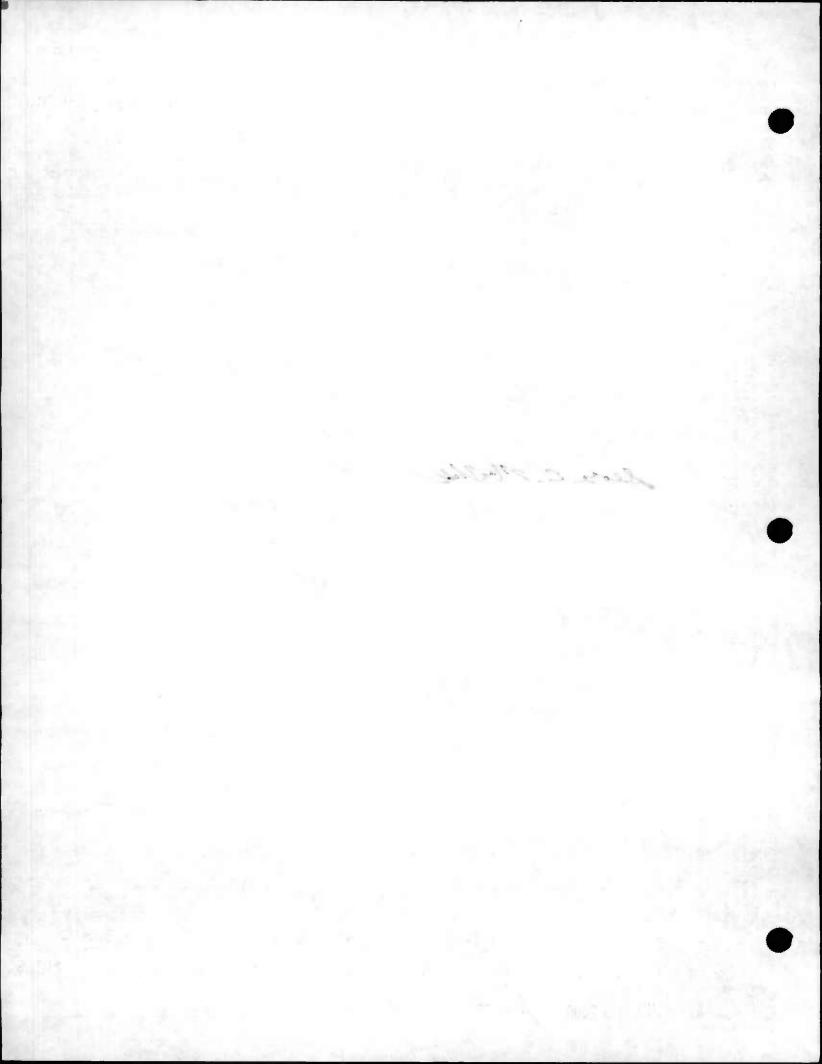


State of Maryland / Department of Health and Mental Hygiene 22173. Certificate of Death 2. Dete of Death 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) July July **Physician** Pessy 641 AM HODIN 11 7.000 /Medical 4b. City, Town, or Location of Deeth 4a Facility Neme (If not Institution, give street and number) 4c. County of Deeth Examiner Baltimore Hospital Center HAYOOY N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Deys 1 M 2 F Hours Director 215-40-7617 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 ☐ Yes 2 No Brooklyn Park MD Anne Arundel 'natural', or items 23a or 28a-f 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ğ 21225 264 Rupert Circle USA Funeral Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☒ Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) Store Clerk Discount Dept. Store 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is merked of Charles W. Hensler Katie Galloway 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19e. tnformant's Name/Relationship (Type, Print) Charles E. Hensler / brother 262 Rupert Circle Brooklyn Park, MD 21225 20b. Ptace of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from Stete 07/12/00 Metro Crematory, Inc. Baltimore. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Marchite Cremation Society of MD. Inc. George E. MacNabb 299 Frederick Road Baltimore, 21228 MD 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Deural effusion /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner ennucer of right brenst ettending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in deeth) Last Due to (or es e consequence of): Physician/Medical Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco was contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown chest of right by 24b. Were eutopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? Completed hes 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes cese referred to medicat examiner? Be 26. Plece of Death (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Hospitel: 1 Inpatient s after death.

I Director: After this conditions on by the funeral directors edicai Certification; To 2 ER/Outpatient 3 DOA 27. Manner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death.

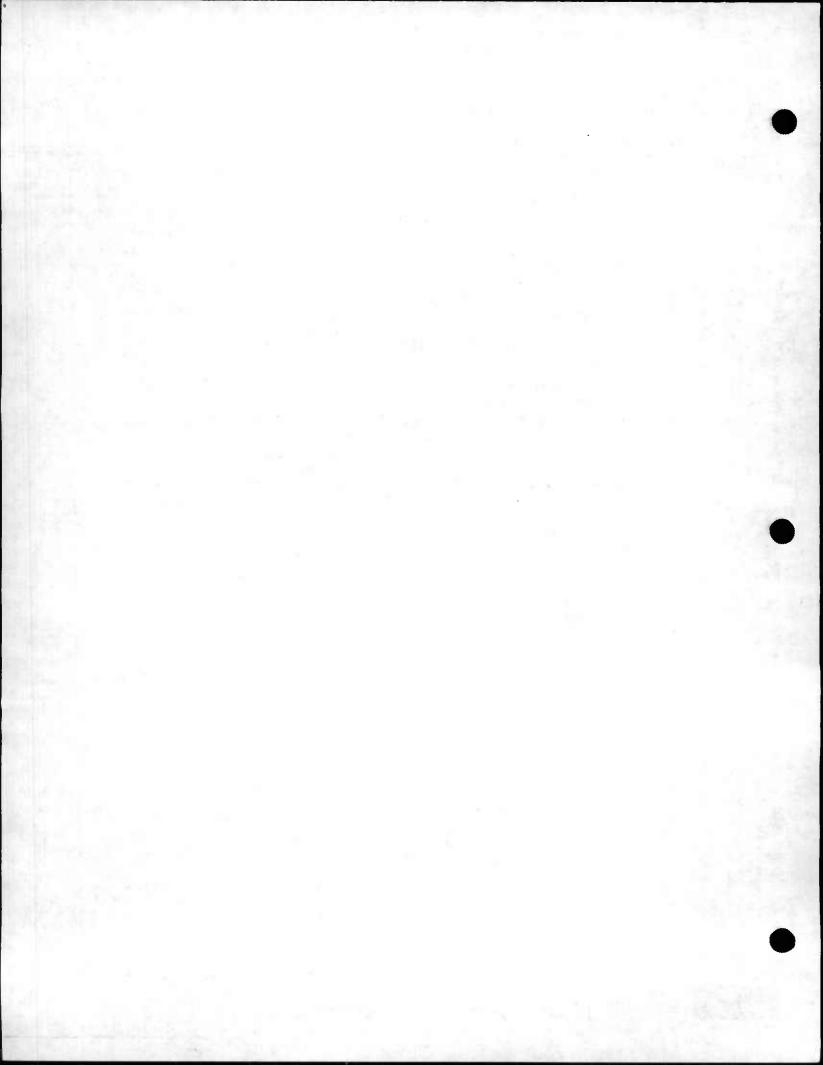
To the Funeral Director: After 1 Netural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Sulcide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) **4** ☐ Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and plece, and due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier pletely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of certifier ms. July 11, 2000 re5001 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) South HANDWER Street, Baltimore, Maryland 21225 Peter 3001 Crais MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State outs Registrar 1 3 2000



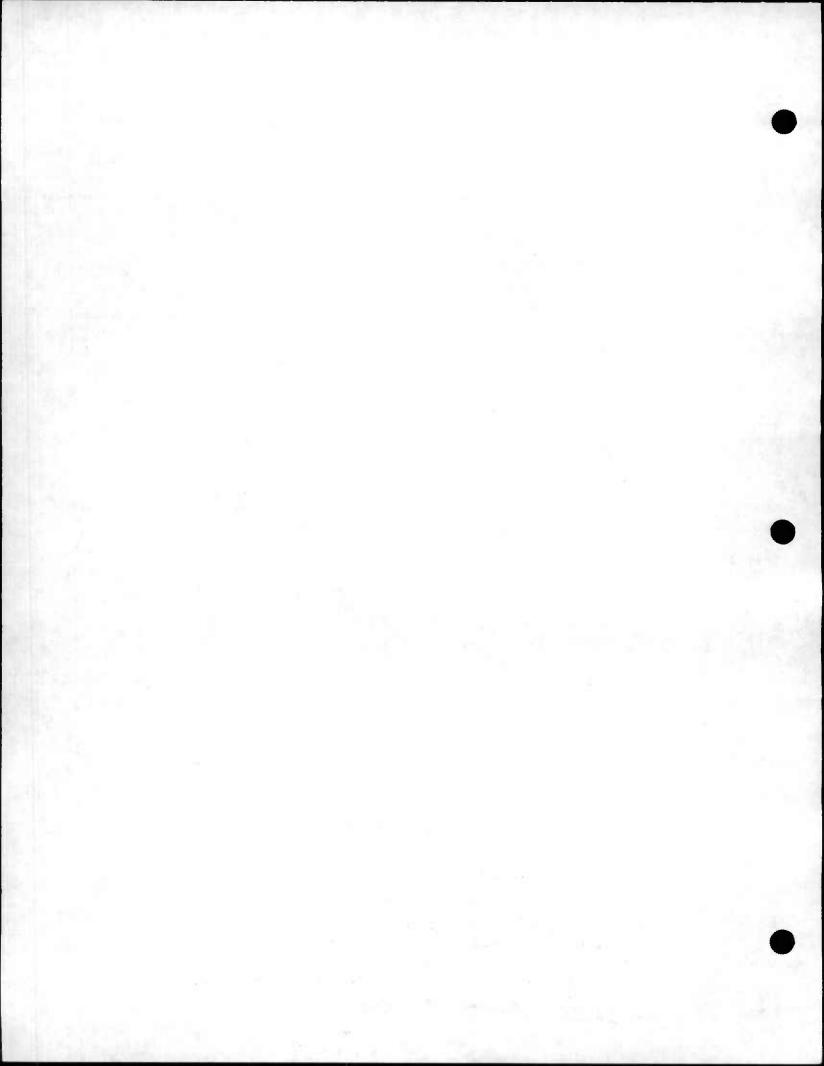
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			cher/Wife	92	214 Tune	make	r Terra	ce Colum	bia, Md.	21045 City or Town, State	
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State of Maryland / Department of Health and Mental Hygiene 00 22175

-				Cer	tificate of	Death			Reg. No.	0	44110
Dhualalau	1. Decedent's Neme (First, Mic	idle, Last)						2. Date of De Month	eth Day	Year	3. Time of Deeth
Physician Medical	Christophe	r Scott	t Sta	rk				July			550 an
Examiner	An Cantilla Stome Minet Institut	tion, give street end nu oll Gate Ro	m <i>ber)</i> Dad			-	own, or Local	ation of Deet	4c. County		
Funeral Director	5. Social Security Number 205-44-3391	6. Sex 1 XM 2 ☐ F	7. Age (In yrs. las	st birthdey) Yrs.	If Under 1 Yeer Months Deys	If Under Hours	Min.	B. Dete of Bir (Month, De July	th by, Year) 2,1968	9. Birthp Cour Pa	olece (Stete or Foreigntry)
P	Usual Residence of Decedent		T								
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vith the Mar or 28s-1 a be notified Director	10e. Street and Number	Tel Sc			10f. Zip Code	100			10g. Citizen of	Whef Country?	
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72 hours enatural, o	3 Widowed 4 Divorc	ed Year or D	ates:						Openi	, AA11.	1.00
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Ne Hospitai n 24 hours Ne Funeral pletely filled edical C	29a. Certifier 1 Certify (Check only 2 Medic	ring Physician: To the	asis of examination	edge, deeth n end/or inv	occurred at the ti estigation, in my	me, dete er opinion, des	nd ptace, er ath occurred	nd due to the	ceuse(s) and m dete end place,	anner es s	stated. o the cause(s)
within 2 To the comple			ner steted.		29c. Licens	se number			29d. Date signe	ed (Month.	Day, Year)
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2	30. Name and address of person	on who completed caus	e of death (Item 2			Balt	imore	. Marv	land 21	201	
State	31. Dete filed (Month, Day, Yea	"	egistrar's Signatur	2	bouter		-INLC.	, rich y		cu I	
Registrar	JUL 1 3 20	100	1	1	yours						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death JULY 9, 2000 STINCHCOMB 5:30 A.M. 4e Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death CROFTON CONVALESCENT CENTER CROFTON ANNE ARUNDEL If Undar 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) OCT. 2, 19 Birthplaca (Stata or Foraign Country)
 MARYLAND 7. Age (In vrs. last birthday) Days 1□ M 2 F Months Hours 92 1907 10c. City, Town or Location 10b. County 10d. Insida City Limits 1 ☐ Yes 2 No ANNE ARUNDEL SEVERN 10f. Zio Coda 10g. Citizan of What Country? 1231 OLD CAMP MEADE RD. 21144 UNITED STATES 13. Was Decedant of Hispanic Origin? (Specify Yas or Notif Yas, specify Cuben, Maxican, Puarto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indien, Biack, Whita, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Never Married 2 Married 1 ☐ Yas 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) HOSPITAL WORKER MEDICAL 17. Fathar's Name (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Surneme) INEZ WATTS 19a. informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, State, Zip Coda) STANLEY H. STINCHCOMB/ SON 1229 OLD CAMP MEADE RD., SEVERN, MARYLAND 21144 20b. Piece of Disposition (Nama of Data 20c. Location - City or Town, Stata JULY 2000 cematery, crematory or other placa) 1 Burial 2 ☐ Cremetion 3 ☐ Removal from State 12 GLEN BURNIE, MARYLAND GLEN HAVEN MEM. PARK 4 ☐ Donation 5 ☐ Other (Specify) Funeral Service Licensee 22. Nama end Addrass of Fecility
KIRKLEY-RUDDICK FUNERAL HOME, P.A. 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset end Death Achlasia 0 years Dua to (or as a consequanca of): Due to (or as a consequenca of): Due to (or as a consequanca of): 23b. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner

> burial-tran and

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ate has been signed by the page 2 should be detached

After this certificate has

funeral director,

rilled in by the fu

physician

Examiner

Physician/Medical

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Completed

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Medical Certification: To

Physician

/Medical

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Funeral

Director

d other than "natural", or itema 23a or 28a-f show event, the Medical Examiner must be notified at

Hygiene.

permit. Pages 1 and 2 should be file Department of Health and Mental Ity Important: if flem 27 is marked oth any Injury or other traumatic even DRBs.

Funeral Director

Completed by

Be

filed within 72 hours after death with the Meryland

Baltimore, Maryland 21215-0020

LONETTA

10a State

MARYLAND

11. Marital Status

10e. Street and Number

THOMAS UPTON

20e. Mathod of Disposition

21. Signeture

5. Social Security Number

Usual Residence of Decedent

213-22-0732

0.

Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Immedieta Cause (Finat disease or condition rasulting in death)

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Hypertension

1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy

24b. Were autopsy findings available prior to complation of causa of death?

1 Yas 2 No

28d. Dascribe how injury occurred

1 ☐ Yas 2 ☐ No

26. Placa of Deeth (Check only ona) Other: 4K Nursing Homa 5 Rasidence 6 Other (Specify)

1 Yas 2 No 27. Manner of Deeth 1 ☑ Naturel 2 Accident

3 Suicide

4 Homicide

25. Was casa referred to medical axaminar?

5 Pending invastigation

28a. Deta of Injury (Month, Day Year) 6 ☐ Could not be

Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of Injury

28a. Placa of Injury - At home, ferm, streat, factory, offica building, etc. (Specify)

28c. Injury at Work? 1 Yas 2 No

28f. Location (Street and Number or Rural Routa Number, City or Town, State)

29e. Certifier

12 Certifying Physician: To the best of my knowledge, death occurred at tha time, data and place, and due to the cause(s) and mannar es stated.

2 Medical Examiner: On the basis of examination end/or invastigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) end mennar stated.

29c. Licansa number

29b. Signature and little of certifier

MI

D38958

29d. Data signad (Month, Day, Year) JULY 10, 2000

3 Daniel & Eabdr & INGHon Sto DHU lete Mau D of deeth (Item 23a) (Type, Print)

1413 ANNAPOLIS RD., #106, ODENTON, MARYLAND 21113 31. Data filed (Month, Day, Year)

JUL 13 2000 32. Registrar's Signature

DHMH 16 Rev 6/95

State

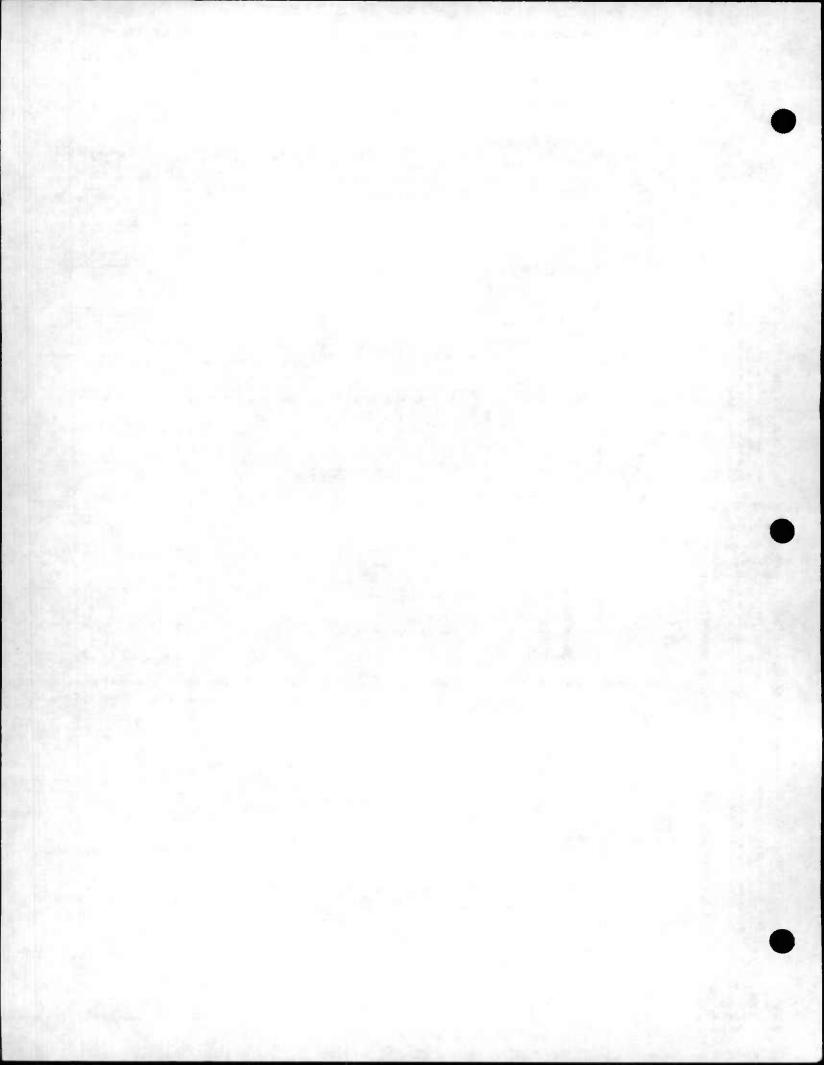
Registrar

Box 68760 P.O. of Vital Records.

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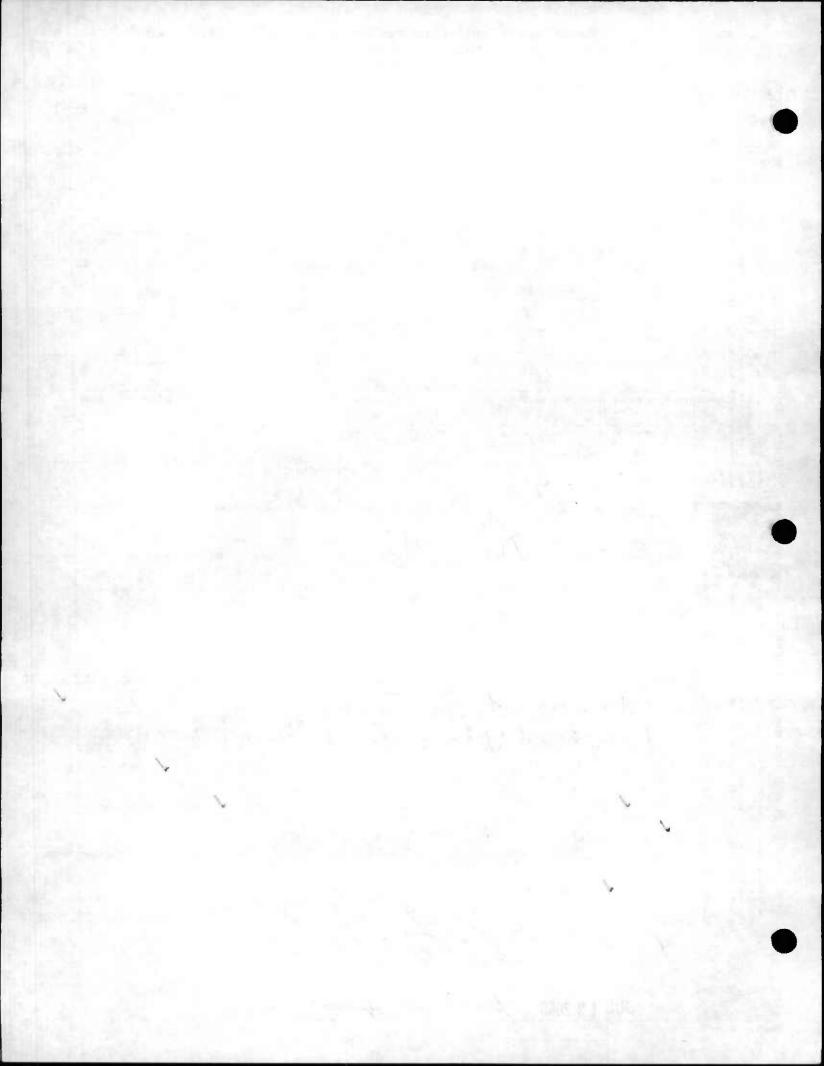
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To the Hospital o within 24 hours af To the Funeral Di completely filled is



State of Maryland / Department of Health and Mental Hygiene 00 22177

	Certificate of Death Reg. N	vio.								
	Decedent's Name (First, Middle, Last) 2. Date of Death Month Decedent's Name (First, Middle, Last)	3. Time of Death								
Physician /Medical	Jack Starr July 9	2000 6:32 PM								
Examiner	to Equilibrations (II not in attitudes only attract and number)	4c. County of Death								
	6406 Golden Ring Road Rosedale	Baltimore								
Funeral Director	572-46-1396 112M 2L F 71 Yrs. 37 JUL 19, 1	928 Sirthplace (State or Foreign Country) England								
Du *	Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location	10d. Inside City Limits								
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after death with the Menyland or frame 23s or 28s-1 show mans the notified at	10e. Sireet and Number 10f. Zip Code 21237	Citizen of What Country? USA								
- P - E - D	3 Widowed 4 Divorced Year or Dates: 1953-56	14. Raca · American Indian, Black, White, etc. Specify: White								
5-0 72 ho	15. Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working	Kind of Business/Industry								
	Elementary/Secondary (0-12) College (1-4or 5+)	Communications								
be file by dother event,	17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maide, en Sumeme)									
aryiai should b and Ment marked umarice	Cyril Starr Gladys Ash									
re, Mar 1 end 2 sho Heelth end 1 mar 27 is m	19a. Informant's Name/Relationship (Type, Print) Elizabeth L. Starr/Wife 19b. Mailing Address (Street and Number or Rural Route Number, City 6406 Golden Ring Road Rose									
Baltimore, Maryjand 212: semit. Pages 1 and 2 should be filed within Department of Health and Mantel Hygiene. Important: If item 27 is marked other than any Injury or other treumstic event, the state. To Be Compl	20e. Method of Disposition 1	Location - City or Town, State								
Baltimor permit. Peges Department of Important: If it eny Injury or o	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Cremation Society of MD 299 Frederick Road Balt:	, Inc.								
8 11 1	23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line.	Approximete Interval Between								
Physician /Medical Examiner	Immediate Cause (Final	Onset and Death								
in the second	Due to (or as a consequence of):									
58760, Care be executed physician end sthe burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury									
876(sate be shysicis the but	Cause. Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of):									
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Division or To the Hospital or Attending Ph within 24 hours after deeth. To the Funerel Director: After thi completely filled in by the funeral Medical Certification:	29a. Certifier (Check only one) 29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause of the course of the course of the cause of the course of									
To the within To the comp	29b. Signature and title of certifier 29c. License number 29d. t	Date signed (Month, Day, Year)								
25		July 10, 2000								
3	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Robert Hsiao, M.D. 5601 Loch Raven Blvd. Baltimore, M	4D 21239								
State	24 Date filed (Month Day Voor) 20 Decistored Circoture	10 21207								



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle Last) 2. Date of Death 3. Time of Death Dey **Physician** 12, 2000 12:45 AM Donald James Simmons July /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Parkville Oak Crest Village Care Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Dey, Year) FEB 17, 1909 9. Birthplace (State or Foreign Country) Maryland 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1⊠M 2□ F Months Days Hours Yrs. Director 216-10-0240 91 Usual Residence of Decedent death with the Maryland 10b. County 10c. City. Town or Location 10d. Inside City Limits show 1 ☐ Yes 2X No Funeral Director Parkville Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 or Herna 23a 8832 Walther Boulevard 21234 USA 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Merried 21215-0020 1 Yes 2 No Specify: Specify: Be Completed by 34 Widowed 4 □ Divorced White natural', 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Military Elementary/Secondary (0-12) College (1-4or 5+) 12 Sealift Command Chief Electrician Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) and 2 should be marked Richard Franklin Simmons Margaret Donighan 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) .00 Joyce Pflum/Daughter 411 Hillsmere Drive Annapolis, MD 21403 Department of Health Important: If Item 27 | Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State Pages 1 20c. Location - City or Town, State 6 Metro Crematory, Inc. 7/12/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, MD iny injury 21. Signature G Puneral Service Licenses Cremation Society of MD, Inc. Edward A. Gregorchik | Cremation Society of MD, 299 Frederick Road Balt |

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Baltimore, MD 21228 Approximate Interval Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical ENDSTAGE DEMENTIA Examiner Due to (or as a consequence of) The law requires that the death certificate be executed page 2 should be detached for use as the burial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Completed by Physician/Medical Due to (or as a consequence of): Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contributs to the cause of death? 1 Yes 2 10 3 Probably 4 Unknown Division of Vital Records, 24b. Were eutopsy findings aveilable prior to completion of cause of death? 24e. Was an autopsy performed? 280 No 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this To the Hospital or Attending Phy within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of 27 Manner of Death 1 Natural 28e. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred 5 Panding investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homlcide Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and placa, and due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end place, end dua to the cause(s) and manner stated.

State Registrar

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31. Date filed (Month, Dey, Year)

29b. Signature and title of certifier

JUL 1 3 2000

aulkner

32. Registrar's Signeture

29c. License number

25643

29d. Date signed (Month, Day, Year)

Bactimer ND 21234

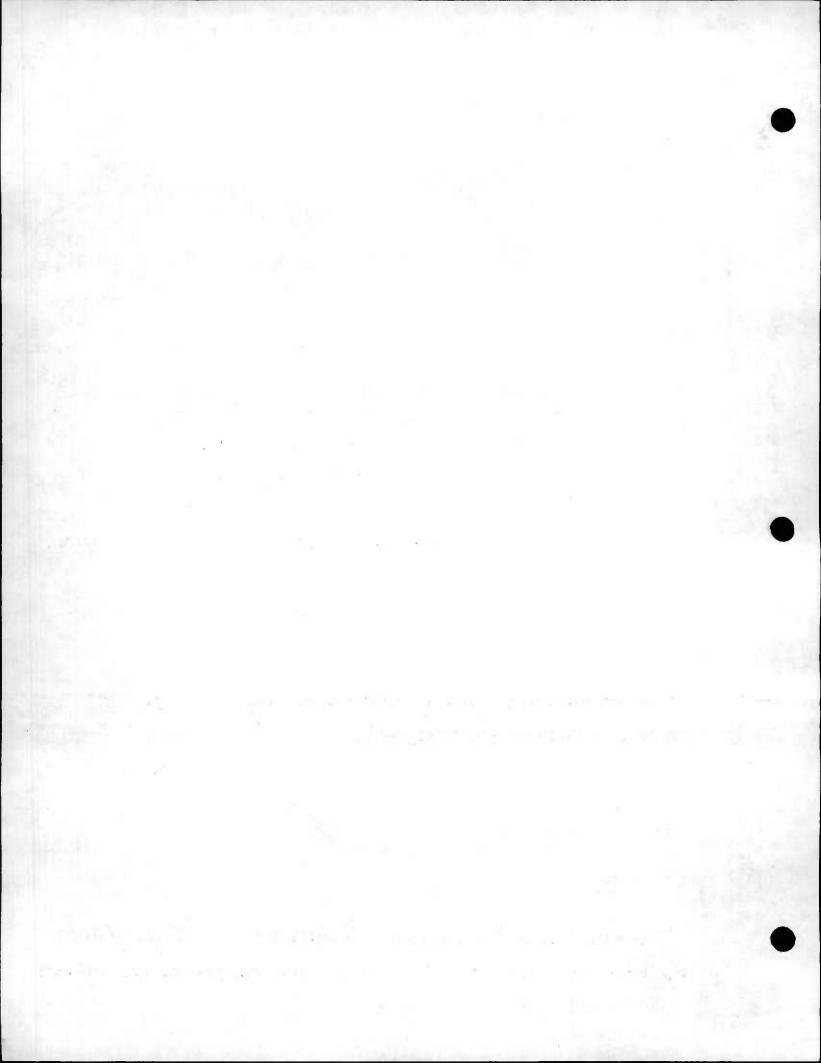
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State of Maryland / Department of Health and Mental Hygiene 22179 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 2000 7:07 AM Arthur E. Vail, Sr. ULV 10 /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death **Examiner** N/A Baltimore St. Agnes Hospital If Under 24 Hrs. Hours Min. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) **Funeral** Months Days 15 M 2□ F 74 Yrs. 218-22-3313 Feb. 15, 1926 Maryland Director Usual Residence of Decedent the Meryland 10c. City, Town or Location 10a. Stete 10b. County 10d. Inside City Limits Show r than "natural", or Name 23a or 28a-f show the Medical Examiner must be notified at Maryland 1 X Yes 2 No N/A Baltimore Directo 10f. Zip Code 10a. Citizen of Whet Country? 10e. Street and Number with 21227 U.S.A. 1112 Plover Drive Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Ricen, etc.) filed within 72 hours efter TRYes 2□No 1944-frYes, Give 1 ☐ Never Married 2 ☑ Married 21215-0020 White 1 Yes 2 No Specify: by Specify: 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondary (0-12) College (1-4or 5+) Electrical Electrician 10 7 is marked othe traumatic event, Maryland permit. Pages 1 and 2 should be file Department of Health and Mentel Hy Important: if item 27 is marked oths any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surname) Be Susie Harrell Phillip T. Vail 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1112 Plover Drive, Arbutus, MD. 21227 19e. Informant's Name/Reletionship (Type, Print) Shirley L. Vail, wife Baltimore, 20a. Method of Disposition 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7-12-00 Loudon Park Cemetery Baltimore, MD 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Neme end Address of Fecility Ambrose Funeral Home, Inc. Tick Daughul 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Part1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) IN FAMCTION /Medical MYOCARDINE Examiner Due to (or as a consequence of) Examiner PACE MAKER ARDIAL The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last burial-tren Due to (or as a consequence of): pue Box 68760. effending physician Physician/Medical the Due to (or es e consequence of) USB as 1 Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached ል 1 Yss 2 No 3 Probably M Unknown þ Records, 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed page 2 certificate hes 1 Yes 2€ No 1 ☐ Yas 2 ☐ No of Vital Physician: funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To this 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred After Division or Attending 1 Natural 5 Pending investigation s after death.

I Director: Aft in by the fur 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled in Cortifying Physician: To the best of my knowledge, death occurred at the time, dete and place, and due to the ceuse(s) and menner es stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier (m) JULY 10,2000 00051865 21 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

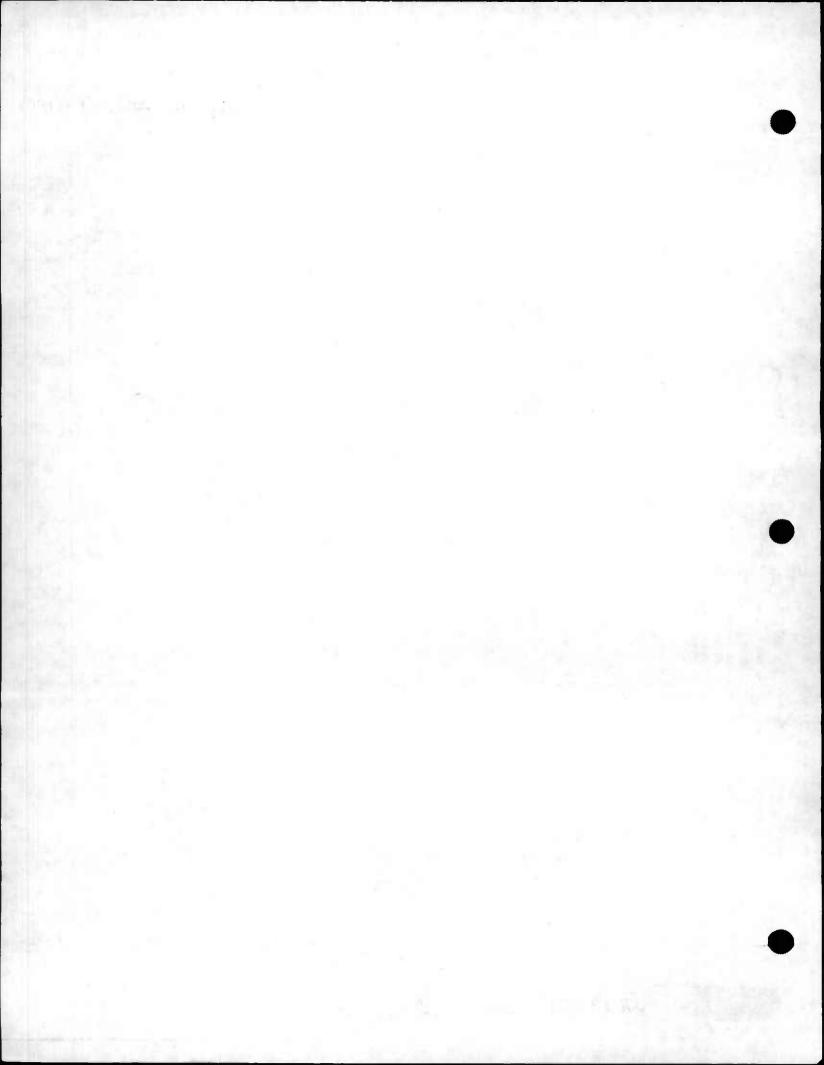
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THE BALTIMORE HUSPITTOL 51 16-NOS 31. Dete filed (Month, Day, Year) 32 Registrar's Signature State Registrar

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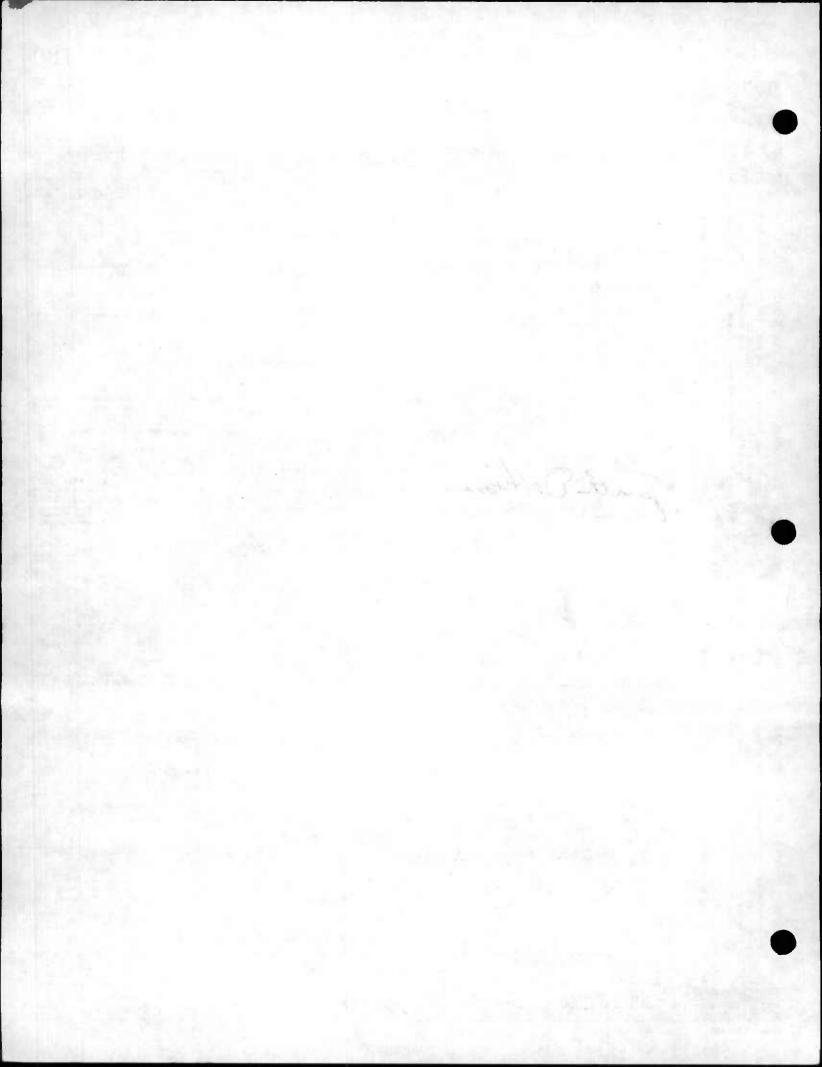


State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Tima of Death Month 2100 **Physician** 514 -013 sul /Medical 4a Facility Name (If not institution, give street and nymber) 4b. City, Town, or Location of Death 4c. County of Death Examiner Maryland BAltimore Medica Sustam If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1 M 2 F 228-68-1314 56 10-3-1943 ŃC Director Usuai Residenca of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Maryla 1 No Yes 2 No must be notified Director MD. N/A BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code "natural", or items 23a or 3910 THE ALAMEDA 21218 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American indian, Biack, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status filed within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: BLACK þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) -10--0-MANAGER DEPARTMENT STORE 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 88 2 permit. Pages 1 and 2 ahould be Department of Health and Mental Important: If Item 27 is marked of any injury or other traumetic evand Mental la marked ROBERT WINDLEY ELSIE P. BAILEY 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHARLES WILSON (HUSBAND) 3910 THE ALAMEDA BALTIMORE, MARYLAND 21218 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 □ Buriai 2 □ Cremation 3 □ Removal from State WOODLAWN CEMETERY 7-15-2000 BALTIMORE, MARYLAND 4 Donatio § ☐ Other (Specify) 22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. 21. Signatu 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 t1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, ck, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Examiner Physician/Medical Examiner onsis 141 The law requires that the death certificate be executed attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or as a consequenca of) Box 68760. that initiated events resulting in death) Last Due to (or as a consequenca of): signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. 1 Yes 2 R6 3 Probably 4 Unknown Charnic Rang þ 24b. Were autopsy findings aveilable prior to completion of cause ot death? Completed 24a. Was an autopsy performed? Isease peen has 2 No 1 Yes 2 No 1 Yes certificata or Attending Physician: Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 0 1. Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Physi within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral dii 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Piaca of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide edical Certifying Physician: To the best of my knowledge, death occurred at the time, date and placa, end due to the cause(s) and menner as stated.

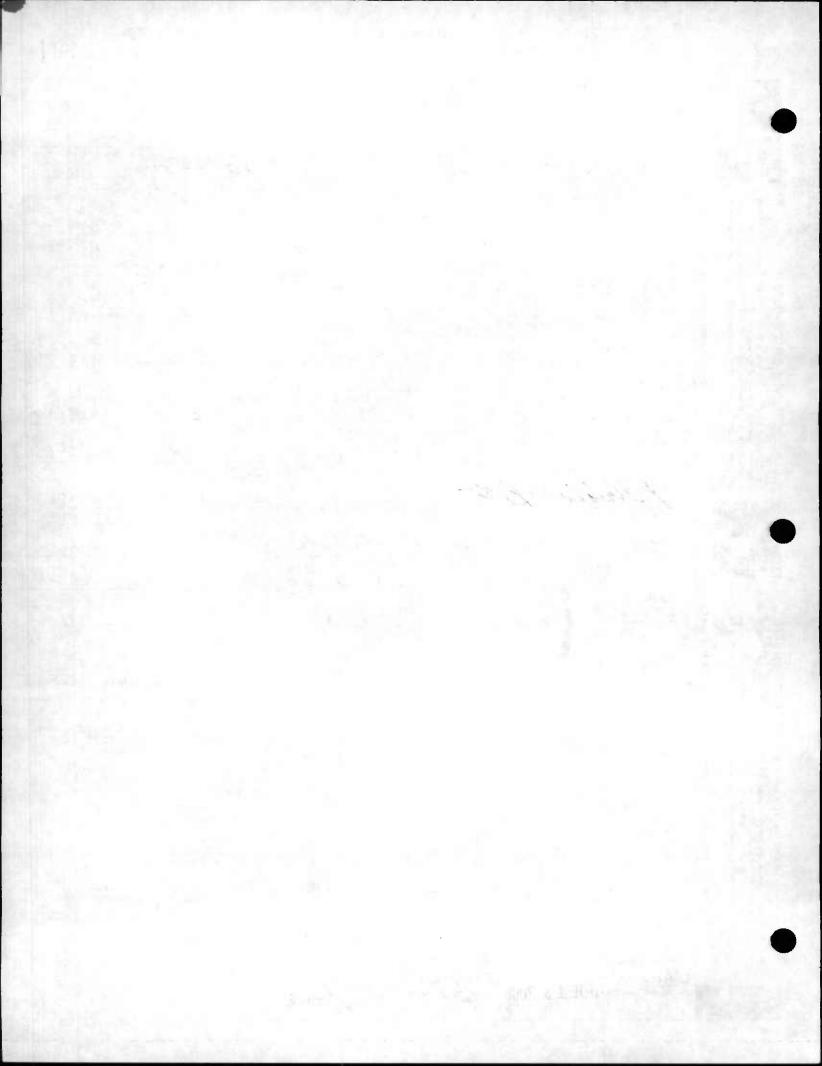
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifier 29c. License number 2000 D DI 30. Neme and address of person who completed cause of death (Item 23e) (Type, Print) Breene Street 22 Sin 14 Ko KERR 31. Dete file 32. Registrar's Signature

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 00 22/8/

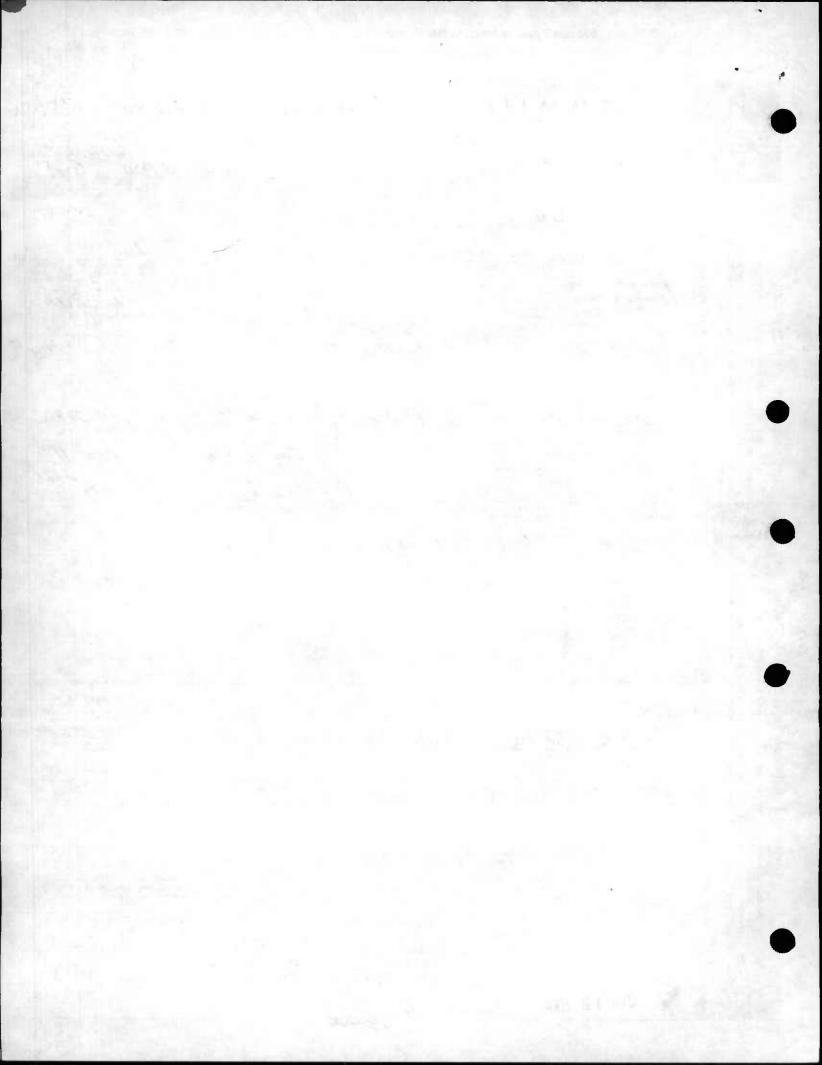
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	Immediate Course (Final	0					
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	resulting in death)	Dua to (or as a consaquenca	of):		- 20.00	24 hours
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Physician	Part II. Other significant conditions	contributing to death but not ra-	sulling in the underlyin	g cause given in Part t.			
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Ë	27. Mannar of Death	28a. Data of Injury	28b. Time of	28c. Injury at Work?	28d. Describ	e how injury occur	red
100	1 Neturel 5 Pending 2 Accidant invastigeti	(Month, Day Year)	Injury M	1 Yas 2 N	No		
Certification:	3 ☐ Suicide 6 ☐ Could not	be 28a. Place of Injury - At h	noma, farm, street, fact	orv. offica	28f. Location	(Street and Numb	er or Rural Routa Number,
FI	4 Homicide	building, atc. (Speci	ify)			own, Stata)	
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edicai	(Check only 2 Medical Exp	hysician: To the best of my kni miner: On the basis of axamin	owleaga, daath occurre etion end/or investiget	eu at tha tima, data and on, in my opinion, deet	a place, and dua to the th occurred at the time	e cause(s) and me a, date and plece,	ennar as stated. end due to the ceuse(s)
Med	one)	and manner stated.	7	20a Lineant a late	TO STATE OF	20d Date -in	d (Month Day Vees)
_	29b. Signatura and titla of cartifiar	· 01 · · · · · · · · · · · · · · · · · ·	1	29c. Licansa number	0.11	250. Data signe	d (Month, Day, Year)
-	CHUN HON	. Chungton	mis	AT2438	746	July, 11	, 2000
1	30. Nama and addrass of person who			Balt inv			
V	Chun Hong,	Union Menyor	nal Hosp.	Balt, mo	re Mo	21218.	
ate	31. Data filed (Month, Dex	3 2000 Registrary Sign	1/4	la- d	- 4		
strar		1	~	Morriso			



Please Type or Print in Black indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death **Physician** 7:30 P.m 2000 09 SOY JU. /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name Whot institution, give street ending Examiner Baltimae
If Under 24 Hrs. 8. Date 6. Sex 10 M 2□ F If Under 1 Year 8. Date of Birth (Month, Dey, Year) 9. Birthplece (State or Foreign Country) Funeral Deys Months Hours Director with the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f show other traumatic event, the Medical Examiner must be northed at 1 Pres 2 No **Funeral Director** 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Maritai Status Bleck, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 Never Merried 2 Merried ryland 21215-0020 1 ☐ Yes 2 No Specify war þ 3 ☐ Widowed 4 ☐ Divorced american "natural". Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working If DO NOT use retired) 16b. Kind of Business/Industry Secondary (0-12) Hygiene. tome other 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Health end Mental -mmmi? ပ ew15 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Stre City or Town, State, Zip Code) permit. Peges 1 end 2: Department of Health er Important: If item 27 Is any injury or other trace 505 MD 21723 20b. Plece of Disposition (Name of cemetery, crematory or other place 3altimore. 20c. Location - City or Town, State Dete 4 Donetion 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licans D.141). one that paused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Intervel Between Onset and Death **Physician** /Medical Immediete Cause (Final disease or condition resulting in deeth) Examiner Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last attending physicien Physician/Medical Due to (or es a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. The law requires that the 3 Probably 4 Dtnknown been signed by 1 Yss 2 No by 24b. Were eutopsy findings sveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 2 1No 1 Yes 2 No 1 Yes or Attending Physician: To Be 25. Was case referred to medical exeminer? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 1 Yes 2 No 1 Impatient 2 ER/Outpatient 3 DOA 5 Residenca 6 ☐ Other (Specify) After this 27. Manner of Deeth 1 D Naturel 28a. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury et Work? 5 Pending investigation within 24 hours after death.

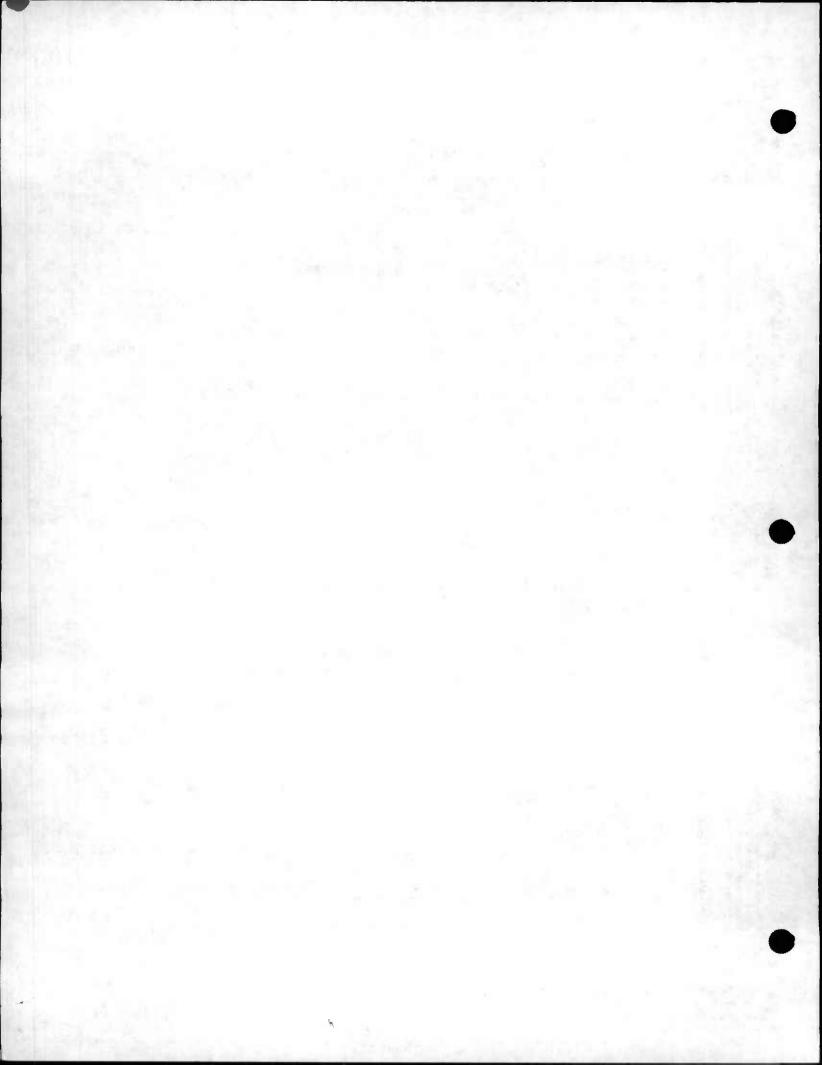
To the Funeral Director; Af 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 | Homicide edical 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and place, end due to the ceuse(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, dete end place, end due to the cause(s) end manner stated. 29e. Certifier (Check only 29b. Signature at a title of pa 29c. License number 29d, Date signed (Month, Day, Year) (Item 23a) (Type, Print) 31. Date filed (Moot) 3 2000 State Registrar

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) 2. Date of Death **Physician** ulu 2000 :37 AM John L. Wetters /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Franklin ose Mare ent Move If Under 24 Hrs. 8. Dala of Birth (Month, Day, Year) Birthplace (Steta or Foreign Country) 5. Social Security Number 6. Sex, 7. Aga (In yrs. lest birthday) **Funeral** Months Days Hours 65 Director 218-30-6592 Maryland Usual Rasidance of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director MD Baltimore Middle River 288-1 10e Street and Number 10f. Zio Code 10g. Citizan of What Country? 23a or 21220 Funeral 136 Trailway RD USA 14. Race - American Indian, Black, Whita, etc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11. Marital Status Was Decedant Evar in U,S. Armed Forcas? Yas 2 No Yas, Giva 1 Never Married 2 Married ð 1 ☐ Yas 2 X No Specify: ģ Specify. 3 ₩Widowed 4 Divorced Yaar or Datas: White Completed Decedent's Usuel Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade complated) 16b. Kind of Bustness/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) Lithographing Baltimore Sun Newspaper 17. Fathar's Nama (First, Middla, Last) 18. Molhar's Nama (First, Middla, Maidan Sumama) Be B 2 Unknown Unknown Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rurel Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) Department of Health Important: If them 27 Rosemary Maszon Sister-in-Law 140 Rodeo Drive Middle River, MD 21220 20b. Place of Disposition (Name of 20a. Mathod of Disposition 20c. Location - City or Town, State Data cematery, cramatory or other place) 1 ☐ Burla1 2 ☐ Cramation 3 ☐ Ramoval from State
4 ☐ Donation 5 ☐ Other (Specify) Balto.-Wash. Crematory 07/14 Laurel, MD 21. Signature of Furieral Service Licansee 22. Name and Address of Facil Bradley Ashton Matthews Funeral Home, Inc. 2134 Willow Spring RD Baltimore, MD 21222 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximata Interval Between Onset and Deeth **Physician** /Medical Immediata Causa (Finet disaesa or condition resulting in death) Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated avents resulting in death) Last Dua to (or as a consequence of) Box 68760 Physician/Medical Dua to (or as a consequence of) 950 P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy certificate has 1 Yas 2 No 1 Yas 2 No 25. Was casa rafarrad to medical examinar? Be 26. Placa of Daath (Check only ona) Hospilal: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidanca 6 Othar (Specify) 1 Yas 2 No Medical Certification: To this 28a. Deta of Injury (Month, Day Year) funeral 28b. Tima of 27. Menner of Death 28c. Injury at Work? 28d. Dascribe how injury occurred After Division or Attending 1 Natural 2 Accidant 5 Panding investigation after death.
I Director: Aft 1 Yas 2 No 28f. Location (Straat and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Sulcida 28a. Place of Injury - Al home, ferm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital o within 24 hours af To the Funeral Di completely filled is TCCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Cartifier 29d. Data signad (Month, Day, Year) 29c. Licanse number 29b. Signature and title of certifier SANJU VARGHESE M.D. 7/12/00 M.D. of person who completed cause of death (Itam 23a) (Type, Print) 9 2000 Franklin Vara 31. Data filed (Morte, May Year) 32. Registrar's Signatura State Registrar



Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene 22184 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death $11^{\,\mathrm{Day}}$ JULY **Physician** 2000° 11:30 PM HELEN M. WOOD /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 8311 ELVATON ROAD MILLERSVILLE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys 1□ M 2000 86 Yrs. Director 215-03-5739 Usual Residence of Decedent NOV. 28, 1913 MARYLAND 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits If item 27 is marked other than "natural", or items 23s or 28s-f show or other traumstic event, the Medical Examinal mast be notified as MILLERSVILLE 1 ☐ Yes 25No MARYLAND ANNE ARUNDEL Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21108 8311 ELVATON ROAD UNITED STATES Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

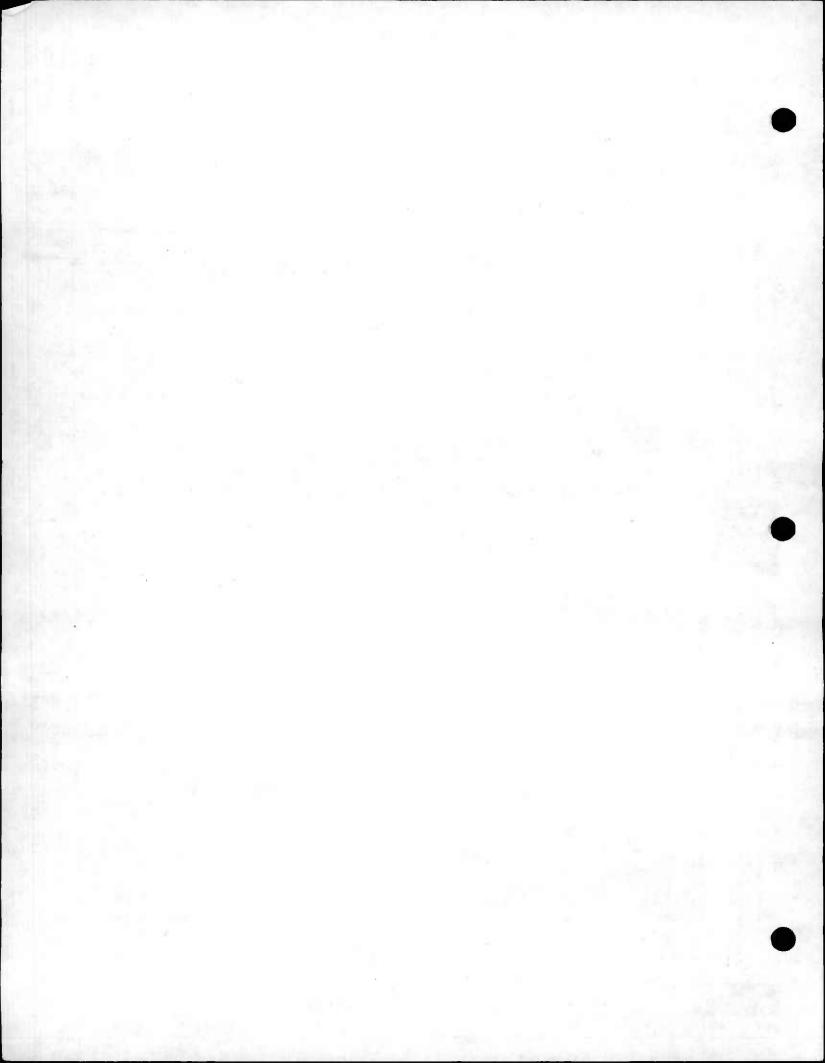
1 Yes 2 No If Yes, Give Year or Detes: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Maritel Status 1 Never Merried 2 Married Baitimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE þ 3√√ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wit. Department of Health and Mental Hyglene Important: if flem 27 is marked other than eny injury or other traumatic event, the kines. HOMEMAKER OWN HOME 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) B PAULUS WAJTOWICZ ANNA RUDNICKA 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) DAVID J. WOOD / SON 8297 ELVATON RD. MILLERSVILLE, MD 21108 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete JULY 14; 1 Burial 2 □ Cremetion 3 □ Removel from Stete 4 □ Donation 5 □ Other (Specify) 2000 GLEN HAVEN MEM. PK. GLEN BURNIE, MD e of Funeral Service Licensee 22. Name end Address of Facility KIRKLEY-RUDDICK FUNERAL HOME P.A. 421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner attanding physician and for use as the burlal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. Due to (or es a consequence of) P.O. I ed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 10 10 3 Probably 4 Unknown signed b Records, à cate has been sig.; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? 2 No 1 Yes 210 No certificate 1 Yes Division of Vital Hospital or Attanding Physician: 24 hours after death. Funeral Director: After this certifical stely filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Pesidence 6 Other (Specify) edical Certification: To 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 1 ☑ Neturat 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Dis completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and meaning stated. 29a. Certifier 29b. Signature and title of certili 29c. License number 29d. Date signed (Month, Day, Year) D20094 JULY 13, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ELLIOTT GORBATY, M.D. 7845 OAKWOOD RD. GLEN BURNIE, MD 21061

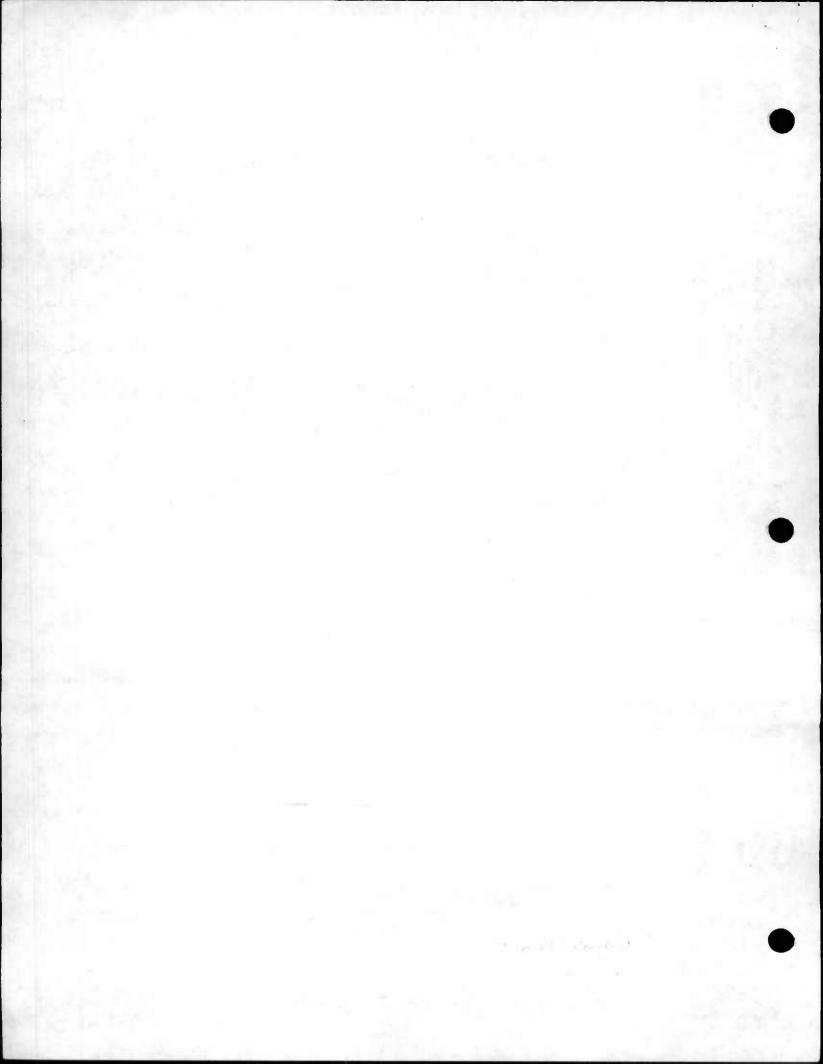
State Registrar

DHMH 16 Rev 6/95

32. Registrar's Signeture

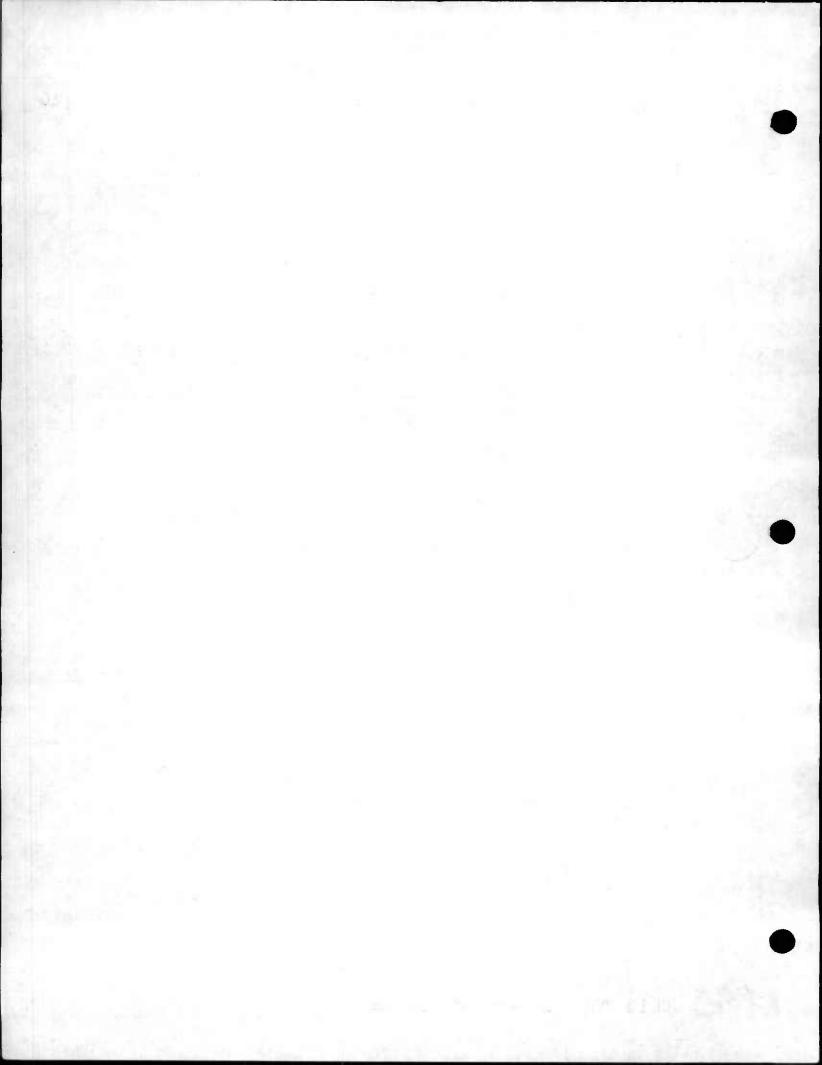


	item 26 per phys. G785 I #26 PER MD G785 7/13,		Certificate of		Reg. No.	0 22185					
	1. Decedent's Name (First, Middle,	Last)		140	2. Date of Death	3. Time of Death					
Physician	Ronald	Wilson			June 29 =	1000 5:55 PM					
/Medical Examiner	4e Facility Name (If not institution, s			4b. City, Town, or L							
LABITITIE	Harbon Hospi	tal Center		Battur	wore.	ALLA					
Funeral	5. Social Security Number 6	Sex 7. Age (In vrs. last		If Under 24 Hrs.	8. Date of Birth	Birthplace (State or Foreign					
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Director.	Usual Residence of Decedent				11/14/19/175	01110					
in a m	10a. Stete 10b. County	10c. City, T	own or Location			10d. Inalde City Limits					
Man Man	MARVIAND A A	. COUNTY C	FLEN B	URNIE		1 ☐ Yes 2 ☐ No					
or 28a-f si be notified Director	10e. Street and Number	County	10f. Zip Code	4,5.0.		What Country?					
	5 WARFIE	IN DONN		2106	1	150					
ther death of the the the the the the the the the the	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of	3-1-0	pecify Yes or No- 14. Ra	ce - American Indian,					
Turn Item	Never Married 2 Married	Arraed Forces?	13. Was Decedent of If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.) Bla	ck, White, etc.					
	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 SNo	Specify:	Speci	h: BIDAN					
72 hours a natural", o lical Exam			6a. Decedent's Usual Occu	nation	16b Kind of F	Business/Industry					
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The second	Elementary/Secondary (0-12)	Coilege (1-4or 5+)		1 ,	ORKER CONSTI	Record Character					
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and and and and and and and and and and	MINNIE BRO			ONHILL		DRE, MD. 21225					
O T T S S S S S S S S S S S S S S S S S	20a. Method of Disposition 1 Burial 2 ☐ Cremation 3		of Disposition (Name of stery, crematory or other ple	ace)	Date / 20c. Location	- City or Town, State					
E September	4 Donation 5 Other (Special		AR HILL (EMETERY	7-06-00 GLEN	BURNIE, MD.					
Series Series	21. Signature of Funerel Service Lice	censee 37/1									
n satisf	21. Signature Funerel Service Licensee 22. Name and Address of Facility DR. FUNERAL HOME 2140 N. FULTON AVE., BALTO, MD. 21217										
MW	23a Part 1 Enter the disease or or	omplications that caused the death. I	lo not enter the mode of du	. FULTOP	or respiratory drest	Approximate					
	shock, or heart failure. List on	ly one cause on each line.	o not onen tilo mode or dy	ing, such os our diad	or respiratory arrest,	Interval Between Onset and Death					
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/Medical Examiner	Immediate Ceuse (Final disease or condition resulting In death) a. Prostate Cancer 5 year										
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HECOLDS, P.O. BOX 5 he law requires that the death certific has been signed by the attending r tge 2 should be detached for use as ompleted by Physician/Me				24a. Was an autopsy	24b. Were autopsy findings						
The law requirate has been signed as should Completed				performed?	available prior to completion of cause of death?						
4 a a c	all the second										
= F # 8 0			1 Yes 2 No								
/Ita	25. Was case referred to medical examiner?	I to a start.			th (Check only one)						
_ S & D	1 ☐ Yes 2 No		Outpatient 31500A		ome 5 ☐ Residenca 6 ☐ O	her (Specify)					
There here	27. Manner of Death	28a. Date of Injury (Month, Dey Year) 28	b. Time of 28c. Injury Wo	ork?	28d. Describe how injury occu	orred					
DIVISION C but or Attending P ts after death. al Director: After t ed in by the funers Certification:	2 ☐ Accident investigat	ion		Yes 2 No							
VIS ARE	3 Suicide 6 Could not determine		, farm, street, factory, office	-	28f. Location (Street and Num City or Town, State)	ber or Rurel Route Number,					
S Sept 5	4 Bromoto	building, etc. (opecity)			ony or roun, ordin,						
a y fills		Physician: To the best of my knowled									
UNUSION O To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral Medical Certification: 3		aminer: On the basis of examination and manner stated.									
Me of the	29b. Signature and title of certifier		29c. Licen	se number	29d. Date sign	ed (Month, Day, Year)					
F \$ F 8		11. 40	D	19629	1	19 1040					
	Janiel.	16 m no	9	11731	June	21, 2000					
	Description of the person who completed cause of death (Ifem 23a) (Type, Print) Daniel Kohn MA 30015 Hand vec Street Battimme, Marylans 21225 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 13 2000 Degree & Aparks										
	1 -		a) (Type, Print)		1. 1						
	Daniel Kohn ma	30015 Hanovecs	treet Bal	tumne, A	Panylans 21225						
State Registrar	1 -	30015 HANDURCS	street Bal	tumne, M	Parylans 21225						



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nema (First, Middla, Last) 2. Dete of Death Day Year WISE **Physician** JUL 0/26 2000 /Medical 4a Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner 0 105 PIT N/AohNS 6 7. Age (Irlyrs. last birthday) If Under 1 Year 5. Social Security Number 6. Se Birthplece (State or Foreign Country) **Funeral** Months Deys 1 ☐ M 2 🖔 F 033-30-5122 Director Poland Poland Usuel Residenca of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f ehow f Health and Mental Hygiene. Item 27 ie marked other than "natural", or items 23a or 28a-f ehov other traumstic event, the Medical Examinar must be nothited at MD N/A Baltimore Yes 2 No Director 10e Street and Number 10g. Citizan of What Country? 10f. Zip Code filed within 72 hours after death with 3407 W. Rogers Funeral 21215 Avenue 14. Raca - American Indien, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedant Ever in U,S. Armed Forces? 11. Maritel Status Bleck, White, atc. 1 ☐ Yas 2 ☑ No If Yas, Give Year or Dates: 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 K No Specify: þ Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 16b. Kind of Businass/Industry College (1-4or 5+) Elementery/Secondery (0-12) telephone operator communications 18. Mothar's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental Gottlieb Finger Hilda Dombrowski 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) Department of Health at Sepontant: If from 27 is any injury or other tra-Fleetwood Wise/spouse 3407 W. Rogers Avenue Baltimore, MD 20b. Ptece of Disposition (Neme of cematary, crametory or other plece) Dete 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 🖾 Other (Specify) in state permit. 21. Signature of Funeral Service Licensee Roma Id S. Wade 22. Name end Address of Fecility Darector State Anatomy Board 655 W. Baltimore Street Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, ock, or heart failure. List only one cause on sech lina. Approximete Intarval Batween Onset and Daath Physician Medical. Immediate Ceuse (Finel MYOCARDIAL 30 MINUTES diseese or condition rasulting in deeth) Examiner Due to (or as a consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laeding to immediate cause. Enter Underlying Causa (Diseese or injury that initiated events resulting in death) Lest Due to (or as a consequence of): and physician Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? signed by I 3 Probably 4 Unknown 1 Yes 2 No þ 24b. Wera autopsy findings eveilabla prior to complation of causa of daath? 24e. Was en eutopsy performed? Completed has 2 No 1 ☐ Yas 2 ☐ No certificate or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Mnpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Home 5 ☐ Residenca 6 ☐ Other (Specify) 2 1 Yes 2 No this funeral 28d. Describe how injury occurred Certification: 27. Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28b. Tima of 28c. Injury at Work? Aftert 1 Natural 5 Pending investigation 1 Yes 2 No death. within 24 hours efter death To the Funerel Director: / completely filled in by the 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, daeth occurred et the time, date end plece, end due to the causa(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, deeth occurred et the time, date and place, and due to the ceuse(s) and mennar stated. 29a. Certifier edical (Check only one) 29c. Licanse number 29d. Data signed (Month, Dey, Year) 29b. Signature 2007 30. Nama and addrass of person who com ALAN STREET, BALTIMORE, MARYLAND GHENG 31. Date filed (Month, Dey, Year 32. Registrar's Signatura State JUL 13 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22187. Certificate of Death 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Yee **Physician** 1:20 a.n luly 06 SYBIL C. WALTERS 2000 /Medical 4b. City, Town, or Location of Deeth 4e Fecility Neme (If not institution, give street end number) 4c. County of Death Examiner Mariner Health-BelAir BelAir Harford if Under 1 Yaar If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) 5. Social Security Number 6. Sax 7. Aga (In yrs. lest birthdey) Birthpleca (Stata or Foreign Country) **Funeral** Months Deys Hours Min 1□M 2X F Yrs. 238-12-9976 Director 81 Jan. 11, 1919 North Carolina Usuel Residence of Dacedent death with the Maryland 10d. Inside City Limits 10e. Stete 10b. County 10c. City, Town or Location Peges 1 and 2 should be filed within 72 hours after death with the Marylar nant of Health and Mental Hygiene. Int: if item 27 is marked other than "natural", or items 23s or 28s-4 show ary or other traumatic event, the Medical Examiner must be notified. 1 Yas XX No MD Harford Kingsville Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 716 Karen Drive USA Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Yaar or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuben, Mexicen, Puerto Ricen, etc.) 14. Rece - American Indian, 11. Maritel Status Bleck, White, etc. 1 Never Married 2 Married specify: White 1 Yes XX No Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 years Hair Dresser Beauty Salon 18. Mother's Neme (First, Middle, Maidan Sumema) 17. Fether's Neme (First, Middle, Last) Be Valturs, Sysic 2 Unknown Pauline Cannedy 19e. Informent's Name/Reletionship (Type, Print) 19b. Melling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Frederick Z. Walters (husband) 716 Karen Drive Kingsville, Md 21087 20b. Plece of Disposition (Neme of cematery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete permit. Pege Department of Important: if any Injury or once. 4 Donetion 5 Dother (Specify)entembrent 7/8/2000 Dulaney Valley Mausoleum Timonium, Balto County,MD 21. Signeture of Funerel Service Licensee 22. Neme end Address of Facility E.F.Lassahn Funeral Home 11750 Belair Rd. Kingsville, MD 21087 Lassahr 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** Accident Immediate Cause (Final disease or condition resulting in death) I month /Medical Cerebrovascu lon Examiner Due to (or es a consequence of): Physician/Medical Examiner attending physician end for use es the bunal-trensit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Ceuse (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Division of Vital Records, P.O. Box 68760, Due to (or es e consequence of) signed by the ail 23b. Did tobseco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown by been sig 24b. Were autopsy findings eveileble prior to completion of cause of deeth? Completed 24e. Wes en eutopsy performed? ete hes b 2 No 1 ☐ Yes 2 ☐ No 1 Yes After this certificate Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice director, Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 ☐ Yes 2 1 No ပ္ 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA funerai 27. Manner of Death 28e. Dete of injury (Month, Dey Year) 28d. Describe how Injury occurred 28b. Time of 28c. Injury et Work? Certification: 1X Naturel 5 Pending Investigation the Funeral Director: After the Funeral Director: After the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral filled in by the funeral fil 1 Yes 2 No 2 ☐ Accident 6 Could not be 3 Suicida 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 4 Homicide 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier To the Hosp within 24 hou To the Fune completely fi 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 29c. License number D34052 July 6, 2000 Bel Air Maryland 21014

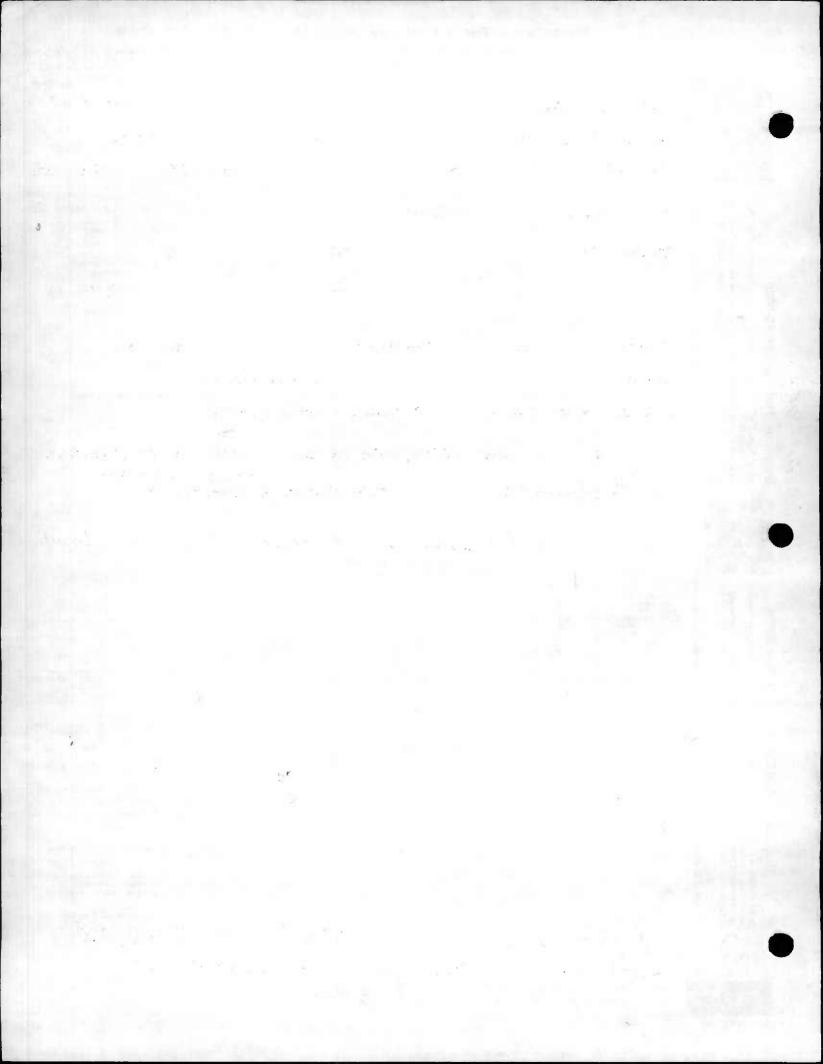
Registrar

State

31. Dete filed (Mg

30. Name and address of person who completed cause of death (Item 23e) (Type, Print)

2 North Avenue



death with the Marylend

show

items 23a or 28a-f sho iner must be notified at

234

Peges 1 and 2 should be filed within 72 hours effer nent of Health and Mentel Hygiene. ant: If Nem 27 ie marked other than "natural", or ffe

27 is marked traumatic e

Depertment of Health e important: If Item 27 is any injury or other training.

Physician /Medical

Examiner

buriel-tran

3altimore, Maryland 21215-0020

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dey **Physician** Raymond James Westberg 9 2000 JULY 2138 PM /Medical 4e Facility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3933 COLCHESTER ROAD BALTIMORE CITY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) Birthpleca (State or Foreign Country) **Funeral** Months Days 110 M 2□ F Hours 218.96.3051 Director 34 09.10.1965 Bethesda. MD Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. tnside City Limits 1 Ves 2 No Funeral Director MD N/A Baltimore 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 3933 Colchester Rd. 21229 USA 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Stetus 14. Rece - American Indien, Bleck, White, etc. 1 ☐ Yes 2 💆 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married 1 ☐ Yes 2 1 No Specify: Specify: δ White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) ĺO Carpenter Trade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Vincent Westberg Catherine Kight 19e. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Catherine Westberg/ Mother 3933 Colchester Rd. Baltimore, Md 21229 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20e. Method of Disposition Date 20c. Location - City or Town, Stete 1 ☐ Buriel 2X Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore Washington Cre.7/11/00 Laurel, MD 21. Signature of Funeral Service Licensee Gary L. Kaufman Fun'l Home @ Meadowridge Mem. Park Mgk. Marsha Inc. 7250 Washington Blvd. Elkridge, Md 21075 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximete tntervel Between Onset end Deeth Immediate Cause (Final HANGING disease or condition resulting in deeth) Due to (or es e consequence of): Physician/Medical Examiner Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of) Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 2 24b. Were eutopsy findings eveilable prior to completion of cause of death? Be Completed 24a. Wes en eutopsy performed? 1₽ es 2□ No 1 Pres 2 No 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 \square Nursing Home 5 \square Residence \lozenge Other (Specify) AT SCENE Hospitel: 1 | Inpatient 2 | ER/Outpatient 3 | DOA edical Certification: To 1 X Yes 2 □ No 28b. Time of Injury FOUND 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred SUBJECT HANGED SELF 1 Neturel 5 Pending Investigation 1 Yes 2 HO FOUND 7/9/00 2 Accident 2121 3 Suicide 6 Could not be 28e. Pleca of tnjury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 70,700 (61.61.61.64) 4 Homicide 3933 COLCHESTER RD AT MOME BACTIMORE, MO 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date end plece, end due to the ceuse(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and plece, end due to the ceuse(s) end menner stated. 29a. Certifier

The law requires that the death certificate be executed Records, P.O. Box 68760, Vital Attending Physician: oto Division i or Attendatation of Director:

this

death.

A 24 hou.

To the Within 2 To the

Hospita

filled in by the funeral

State Registrar

N

MARY 31. Dete filed (Month, Day, Year) JUL 13 2000

29b. Signeture end title of certifier



30. Neme end eddress of person who completed cause of deeth (Item 23a) (Type, Print)

hel.

29c. License number

AIPPLE 111 Penn Street, Baltimore, Maryland 21201

OCME

29d. Date signed (Month, Day, Year)

10, 2000

JULY

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene amend item 23a per phy G786 8/31/00 yf Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Ella Elizabeth Ates June 14,2000 3:00am /Medical 4a. Facility Name (If not institution, giva street end number) 4b. City. Town, or Location of Deeth Examiner 4c. County of Death 6140 Baldridge Circl Frederick Frederick 5. Sociel Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (Stete or Foraign **Funeral** Days Hours 1□ M 25 F Hodge, LA 434-38-9249 72 Yrs. Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location them 27 is marked other than "natural", or frems 23e or 28a-4 show other treumatic event, the Medical Examinar must be incitified at 10d. Inside City Limits MD Frederick Frederick 1⊠Yes 2□No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6140 Baldridge Circle U.S.A. 21701 death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No 11. Maritel Status Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexicen, Puarto Ricen, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours efter Hygiene. hther than "natural", or fte 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 If Yes, Give Yaar or Dates: 1 ☐ Yes 2 2 No Specify: þ Specify: White 3 □Widowed 4 □ Divorced Completed Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12th Home permit. Pages 1 and 2 should be file.
Department of Health and Mental by Important: If them 27 is marked other any injury or other treumatic eventous. 17. Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William Tewell Frankie Lee Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Vicki Boutlier 6140 Baldridge Circle, Frederick, MD 21701 20a. Method of Disposition
1 ☑ Burial 2 ☑ Cremation 3 ☑ Removal from State 20b. Place of Disposition (Neme of cametery, cremetory or other place) 20c. Location - City or Town, State 4 ☐ Donation 5 ☐ Other (Specify) 6-17-2000 Hodge, LA Hodge Cemetery 21. Signature of Funeral Service License, 22. Nama and Address of Facility Gary L. Rollins Funeral Home 21701 nun X 110 West South Street, Fred., 23a. Part1. Enter the disaasa, or co pilicetions that caused the death. Do not enter the mode of dying, such es cerdiac or respiratory Approximete Intervel Between Onset and Death congestive **Physician** Immediate Cause (Final diseese or condition resulting In death) /Medical **Examiner** Examiner buriel-transit Sequentielly list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseasa or Injury that initieted events resulting in daath) Last and Records, P.O. Box 68760 90 Physician/Medical the 80 Po Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown nemia ģ 24b. Were autopsy findings available prior to completion of ceuse of death? Completed 24a. Was an autopsy performed? certificate has 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifice completely filled in by the funeral director, I Be 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No ٩ 28e. Date of Injury (Month, Dey Year) 27. Menner of Death 28b. Time of Certification: 28c. Injury at Work? 1 Natural 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner es stated.

Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and mannar statad. 29a, Certifier edicai (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Deta signed (Month, Dey, Year)

Ct. Frederick, MD. 21703

State Registrar Stephen

31. Date filed (Month, Day, Year)

ee MD.

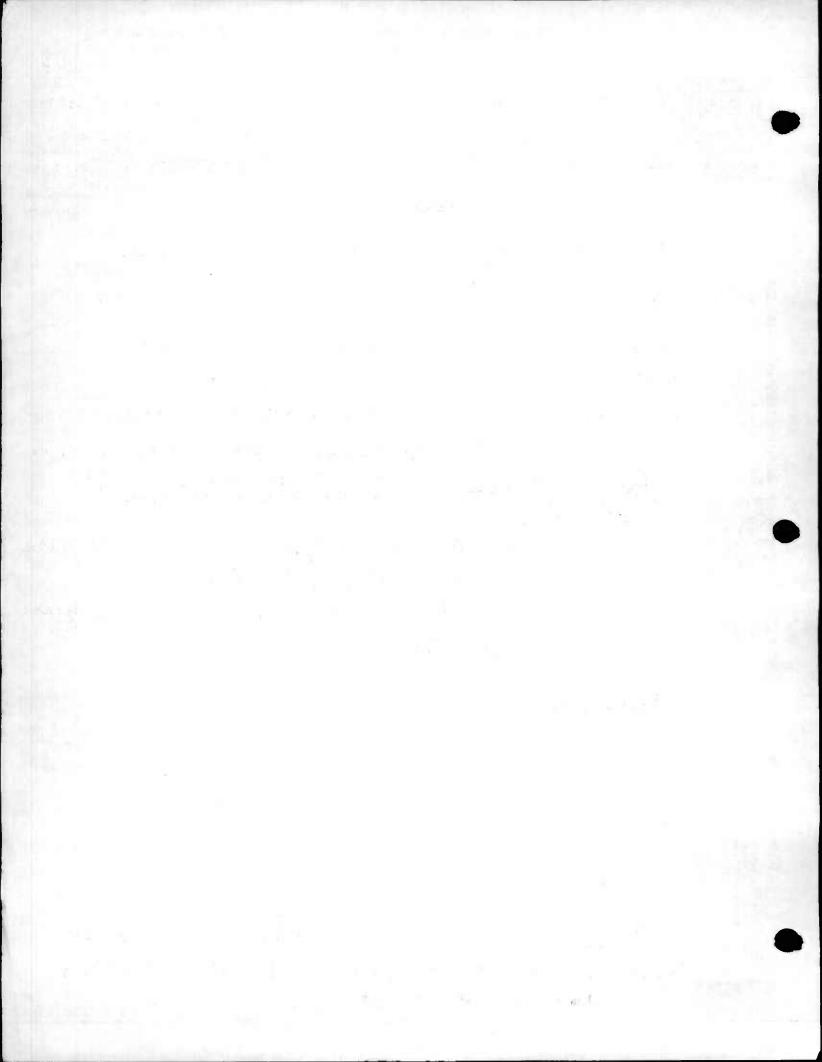
Lee MD

JUN 1 5 2000 >

30. Nama and address of person who completed ceuse of death (Item 23a) (Type, Print)

610 Solarex

32. Registrans Signature



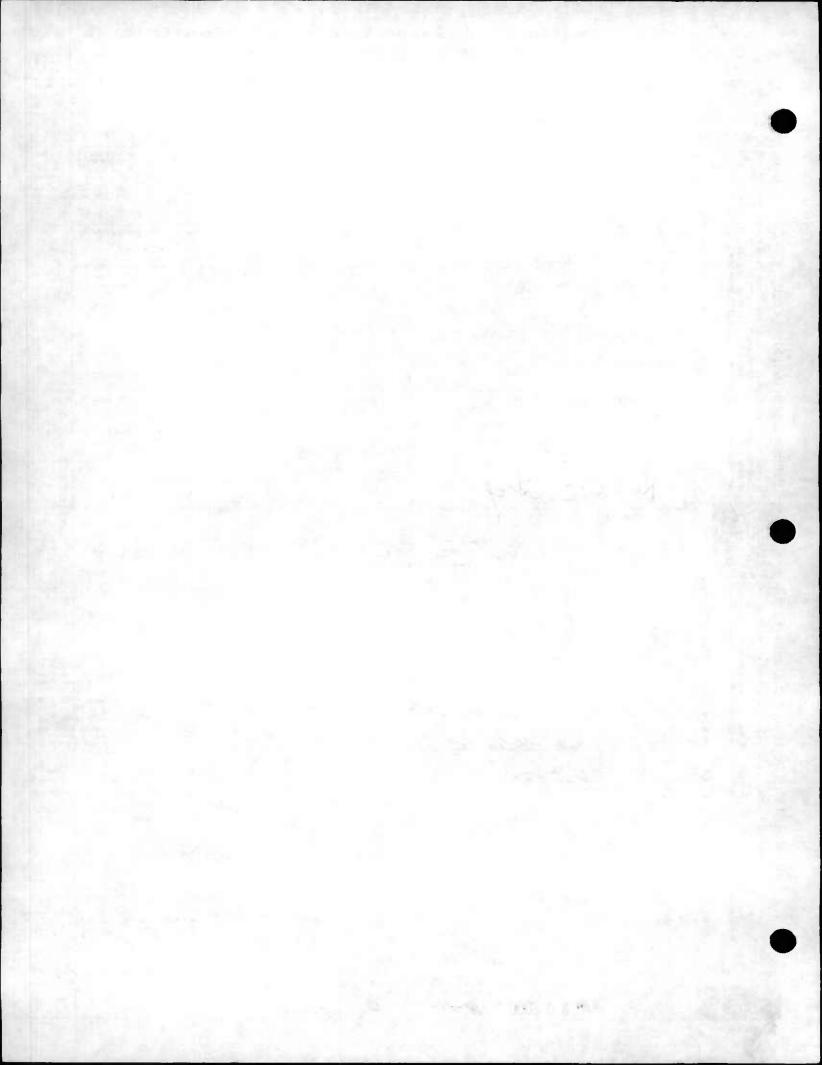
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 29, 02000 Year **Physician** Beulah Odelia Anderson 5:50 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 7024 Edgemont Road Frederick Frederick If Under 24 Hrs. If Under 1 Year 8. Date of Birth Month, Bay, Year, 904 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 XF Virginia 220-16-9457 96 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23s or 28s-f short Maryland Frederick Frederick 1 Yes 2 No Funeral Directo the Medical Examiner must be notif 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 7024 Edgemont Road 21702 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 202No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian Black, White, etc. filed within 72 hours after Naver Married 2 Married 1 Yes XXNo altimore, Maryland 21215-0020 Specify: White Specify XX Widowed 4 ☐ Divorced Completed by Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Waitress Food Service 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Hulver Almedia Love11a Unknown Benjamin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7024 Edgemont Road, Frederick, Maryland 21702 Mrs. Lillie Mae Hill, Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Buriel 2 □ Cremation 3 □ Removal from State Mount Olivet Cemetery, July 1, 2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility
Keeney and Basford P.A. Funeral Home 21. Signature of Funeral Service Licansee MO0255 8 106 East Church St., Frederick, Md. 23a. Part1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Scherotte Cardiovas arla disea Examiner Due to (or as a consequence of) Examiner the burial-transi Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, physician The law requires that the death certificate be Physician/Medical Due to (or as a consequenca of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the causa of death? 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed certificate has 1 ☐ Yes ZUNO 1 ☐ Yes 2 ☐ No 2000 To the Hospital or Attending Physician: 25. Was case referred to medical examiner? edical Certification: To Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Presidence 1 Yes 2 No 3□ DOA 6 Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1-BNatural 5 Pending investigation death. 1 Yes 2 No filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, offica bullding, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) after 4 Homicide within 24 hours a To the Funeral C completely filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and fittle of certific 29c. License number 29d. Date signed (Month, Day, Year) June 29, 2000

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day, Year)

32. Registraris Signatu



Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2. Date of Death Day Month **Physician** LUCILLE E. BARNES JUNE 27,2000 10:22 AM /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOME RY SHADY GROVE ADVENTIST HOSPITAL ROCKVILLE If Under 1 Year If Undar 24 Hrs. 8. Dafe of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthdey) Birthplace (State or Foreign Country) **Funeral** 1 M 2 DXF 133-10-9284 Yrs. Director 85 AUG.6,1914 NEW YORK Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. MONTGOMERY ROCKVILLE Y☐ Yes 2 No Director 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 9701- VEIRS DRIVE 20850 USA Funeral 14. Raca - American Indian, Black, Whife, etc. 12. Was Dacedanf Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puarto Rican, atc.) hours after 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Married 2 Married 5 Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ Specify: WHITE 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 Hygiene. Elemantary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 12 AT HOME 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be of Health and Mental F Item 27 is marked of r other traumatic ever ERNEST R. WITTE EMMA KURTZHOLTZ 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) MARY LU BELOTE-DAUGHTER 213- BIRCH STREET, NE, LEESBURG, VA. 20176 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20a Method of Disposition Date 20c. Location - City or Town, State Department of F Important: If he any injury or of Burial 2 Cremation 3 Removal from State UNION CEMETERY 6/29/2000-LEESBURG, VA. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral HYSONG CO., INC. 6510 - 16th ST, NW, WASH., DC in the caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast. Approximate Interval Between Onset and Deeth 23a. Part1. Enter the disease shock, or heart failure. Physician /Medical immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION ONE HOUR Examiner Due to (or es a consequenca of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Causa (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical the Due to (or as a consequenca of): 98 980 signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yss 2 No Completed by Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of causa of death? 2X No 1 ☐ Yas 2 ☐ No 1 TYas certificate of Vital To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: № Inpatienf 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 28a. Data of Injury (Month, Day Year) funeral 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury et Work? Division 5 Pending investigation Watural 1 Yes 2 □ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 T Homicide **Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) end menner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and menner stated. 29a. Certifier (Check only one) 29c. License number 29d. Dafa signed (Month, Dey, Year) 29b. Signature and title of certifier 39934 JUNE 27,2000 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

DHMH 16 Rsv 6/95

State Registrar STEVEN COULTER, MD

31. Date filed (Month, Day, Year)
JUN 3 0 2000

32 Registrar's Signature

- 15201- SHADY GROVE RD. #202, ROCKVILLE, MD. 20850

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible.

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	/Medical Examiner	4a Facility Name (If not institution, gi	ve street and number)				r Location of Deeth	4c. County of Deat				
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JUN 2 9 2000 State Registrar

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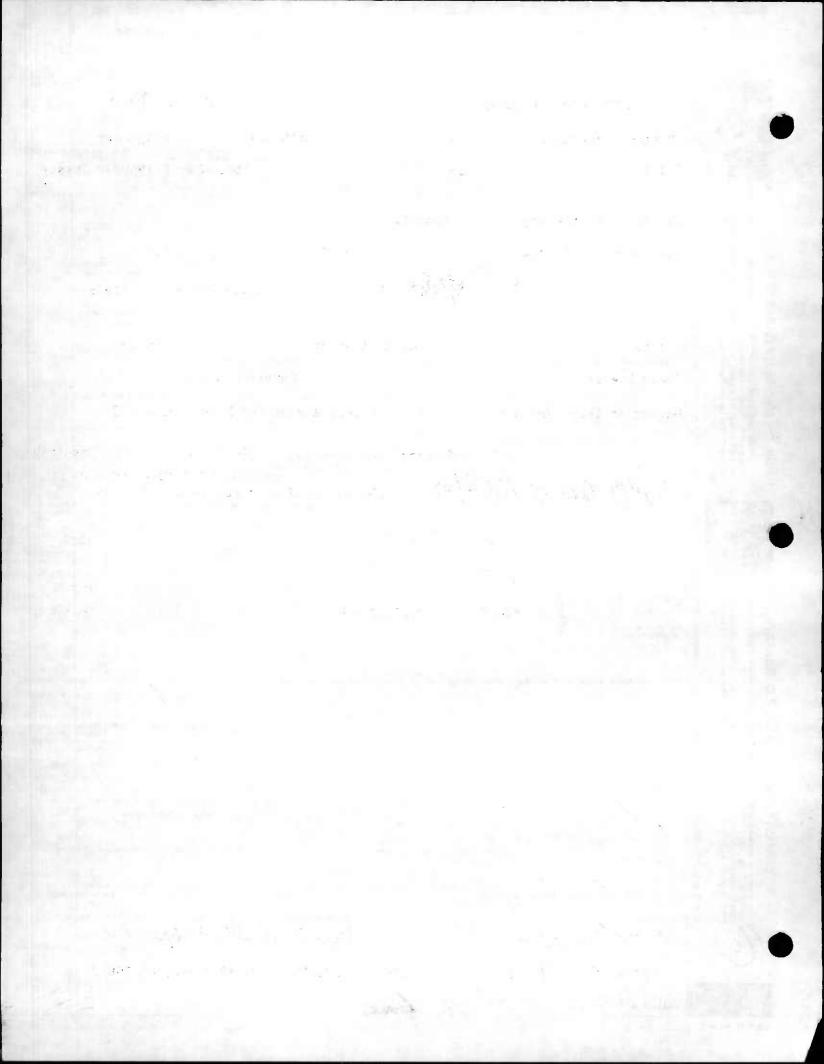
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76)	· Maray	m was	D		050		(MD)	6/25	100			
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DHMH 16 Rev 6/95

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 22 194

			C	ertificate of	Death		Reg. No.				
	1. Decedent's Name (First, Middle,	Last)				2. Date of I		M	3. Time of Death		
Physician	Agnes Mar	io Ratos				June June	Day 26, 2	Year	1:05PM		
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Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death cert within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use	Completed by Physician/M										s an autopsy formed?	ava	ore autopsy findings allable prior to mpletion of causa death?
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Deta of Daeth 3. Time of Death Month Veer **Physician** Redondo Bucero Maria Pilar 23 June 2000 1:40 P.M. /Medical 4a Fecility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 12215 Foxhill Lane Prince George's Bowie If Undar 24 Hrs. 8. Date of Birth (Month, Dey, Year) If Undar 1 Yaar 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 1 M 2 F 217-35-9510 Director Sept. 15, 1912 Spain Usuat Residence of Decedent death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Show r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at 1 Yes 2 □ No Director Prince George's Bowie 10e Street and Number 10g. Citizen of Whet Country? 10f Zin Code 12215 Foxhill Lane 20715 United States Funeral 14. Race - American Indian, Bleck, White, etc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11. Marital Status Peges 1 and 2 should be filled within 72 hours efter nent of Health end Mentel Hygiene. int: If Item 27 Is marked other than "natural", or its 1 ☐ Yes 2 **X**No If Yes, Give Yeer or Detes: 1 Never Married 2 Married 8 Baltimore, Maryland 21215-0020 1 XYes 2 No Specify: Spanish ٥ Specify: Spanish 3€ Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use refired) 15. Decedent's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Own Home 12 -0-Homemaker 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Fether's Name (First, Middle, Last) Be Francisco Redondo Juliana Bucero 0 19a. informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 Department of Health e Important: If Item 27 is any injury or other trace Aurora M. Harris - Daughter 12215 Foxhill Lane Bowie, Maryland 20715 20b. Place of Disposition (Neme of cemetery, cremetory or other placa) 20c. Location - City or Town, State 20a Method of Disposition Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from Stata June 25, 2000 Waldorf, Maryland Huntt Crematory 4 Donetion 5 Other (Specify) 22. Name and Address of Facility 21. Signeture Funeral Service L Evans Funeral Home, Inc. MS1095 16000 Annapolis Rd. Bowie, Maryland 20715 plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. Approximeta Interval Between Onset and Death **Physician** /Medical Immediate Ceuse (Finet Chas diseese or condition resulting in death) Examiner Due to (or as consequence of): Examiner sician end buriel-transit the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury thet initiated events resulting in death) Last Due to (or as a consequence of): physician the buriel Box 68760. Physician/Medical Due to (or es e consequence of): 98 950 Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contributs to the cause of death? signed by I 1 Yes 2 No 3 Probably 4 Unknown à The lew requires 24b. Were eutopsy findings available prior to complation of causa of deeth? Completed 24a. Was an autopsy performed? pege 2 s hes 1 Yes 2 No 1 Yes 2 No of Vital Physician: Be 25. Was case referred to medicat 26. Place of Deeth (Check only one) To 1 Yes 2 No Hospitel: Other: 4 Nursing Homa 5 Residence 8 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funerel 27. Menner of Death Certification: 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attending 5 Pending investigation 1 Yes 2 No hours after deeth. 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 ☐ Suicide à Pleca of Injury - At home, ferm, streat, factory, office building, etc. (Specify) 4 ☐ Homlcide filled in Hospital within 24 hours edical 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and placa, end due to the cause(s) end manner as stated.

| Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred et the time, date end placa, and due to the ceuse(s) and menner stated. 29a. Certifier completely (Check only one) 29b. Signature end title of g 29c. License number 29d. Date signed (Month, Dev. Year) 2000 6 30. Nama end address of person who completed cause of deeth (Item 23a) (Type, Print) 20708 <00C 333 LAURE 31. Dete filed (Month, Dey, Year)
JUN 2 7 2000 37. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** Marian Louise Bailey June 9 2000 0230 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** r Rising
If Under 1 Year If Under 24 Hrs. Calvert Manor Health Care Center Sun 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ M 2 🕏 F Director 221-24-7889 94 11/28/1906 Maryland Usual Residence of Decedent with the Maryland 10a. State permit. Pages 1 and 2 should be filed within 72 hours after death with tha Marylan Dapartment of Health and Mental Hygiane. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City. Town or Location 10d. Inside City Limits 1♥ Yes 2□No Directo Maryland Cecil Cecilton 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 120 Center Street 21913 USA Funera 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3- Widowed 4 □ Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10 Homemaker 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Sumame) Be Charles Long Emma Taylor 2 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret O'Neal/ Daughter Cecilton, P.O.Box 308 Md. 21913 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burlal 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) St. Pauls 6/13/00 Earlville, Md 21. Signature of Funeral Service Lice 22. Name and Address of Fecility Fellows, Helfenbein & Newnam FuneralHome 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Md. 21651 Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical emontia Examiner Due to (or es e consequence of): Examiner e IDM the burial-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last and Due to (or as a consequence of): P.O. Box 68760. physician Physician/Medical Due to (or as a consequence of) 58 957 ding Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco usa contributa to the cause of death? signed by the 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were eutopsy findings evailable prior to completion of cause Completed 24a. Was an autopsy performed? The law certificate has 2 No 1 ☐ Yes 2 ☐-No Be 25. Was cese referred to medicel examiner? 26. Plece of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No P After this To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After the completaly filled in by the funera 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of Medical Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Matural Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a, Certifier 1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the besis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6/9/2000 044373 30. Nents and address of person who completed ceuse of deeth (Item 23a) (Type, Print) 101 Colonial Way Chesapeake Family Practice Rising Sun, Md. 21911 Dr. Joseph Weidner
31. Date filed (Month, Day, Yeer) 3 32. Registrar's Signature State Registrar JUN 1 2 2000

JUN 1 9 2000

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Jessie H. Buckner 07 03 00 10:45 AM 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Cheverly Prince George Hospital Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Dete of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Days Hours 1 № 2 □ F 228-44-5902 Yrs 66 03-11-34 Virginia Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yes 2 □ No Prince George Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4712 Gunther Street 20743 U.S.A. 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 1 Yes 2 No Specify: Specity: Black 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 09 Landscaping Foreman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) David Buckner, Sr. Alice Hughston 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David Buckner, Jr. - Brother 53rd St., SE - Apt. #3-Washington, DC 20019 137 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 07-10-00 Louisa, VA 4 ☐ Donation 5 ☐ Other (Specify) Buckner Family Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Thomasson's Funeral Service, Inc. Thomassen me P.O. Box 512 - Louisa, VA 23093 231. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) LUNG with METASTAJES CARCINOMA 1 years Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Dua to (or as a consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 Probably 4 ☐ Unknown 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed?

Physician /Medical Examiner

Examiner

Physician/Medical

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Medical Certification: To

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permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If Item 27 is marked other any Injury or other trauments offer.

Saltimore, Maryland 21215-0020

burial-transit and Records, P.O. Box 68760 attending physician certificate be use as the The law requires that the deeth Division of Vital To the Hospital or Attending Physician: within 24 hours after deeth.

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25. Was case referred to medical					26. Place of De	eth (Check only one)				
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7. Manner of Death 1 Vatural 5 Pending 2 Accident investigation		28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c.	Injury at Work? 1 Yes 2 No	28d. Describe how injury occurred				
3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, efc. (Specify)					ffice	28f. Location (Street and Number or Rural Route Number, City or Town, State)				
29e. Certifier (Check only one)	1 Certifying Ph 2 Medical Exam	nysician: To the best of my kni miner: On the basis of examination and manner stated.	owledge, death occur ation and/or investiga	rred at t	he time, date and place my opinion, death occu	e, and due to the cause(s) and mar urred at the time, date end plece, a	nner as stated. nd due to the cause(s)			

29c. License number

29d. Date signed (Month, Day, Year)

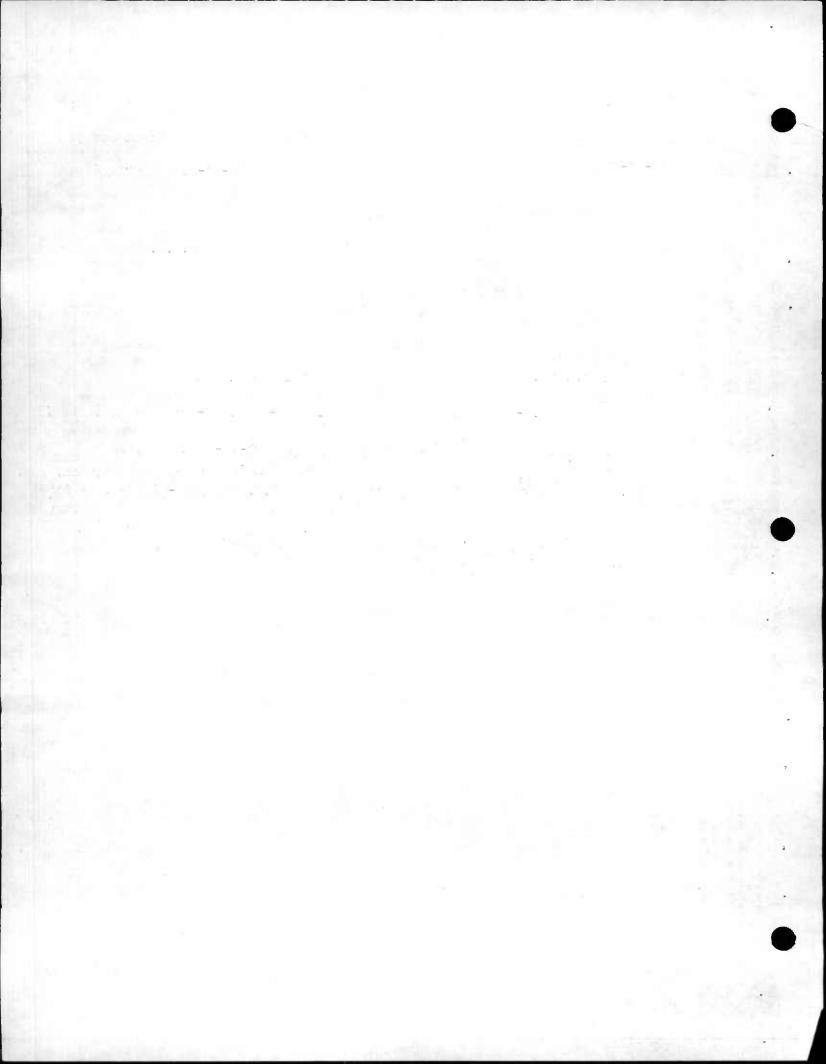
State Registrar 30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

4203 QUEENSBURY Rd Hygtts ille MD 20781 MD 1eRG 31. Date filed (Month, Day, Year)

JUL 13 2000

29b. Signatura and title of certifier

32. Registrar's Signature



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State Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID B. DANNER MD 219 S. WASHINGTON ST. EASTON, MD. 21601
31. Dete filed (Month, Dey, Year) 32. Registrar's Signeture

B. Danner MD

JUN 2 9 2000 >

29b. Signature and title of certifier

29c. License number

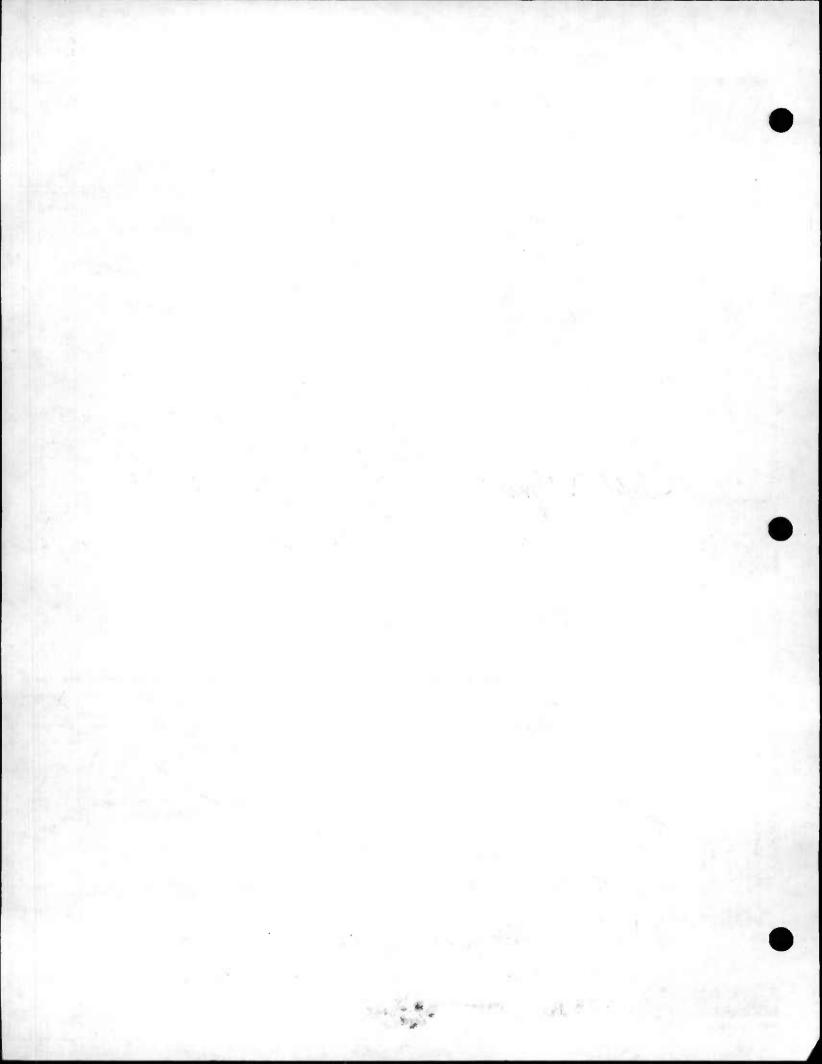
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State of Maryland / Department of Health and Mental Hygiene

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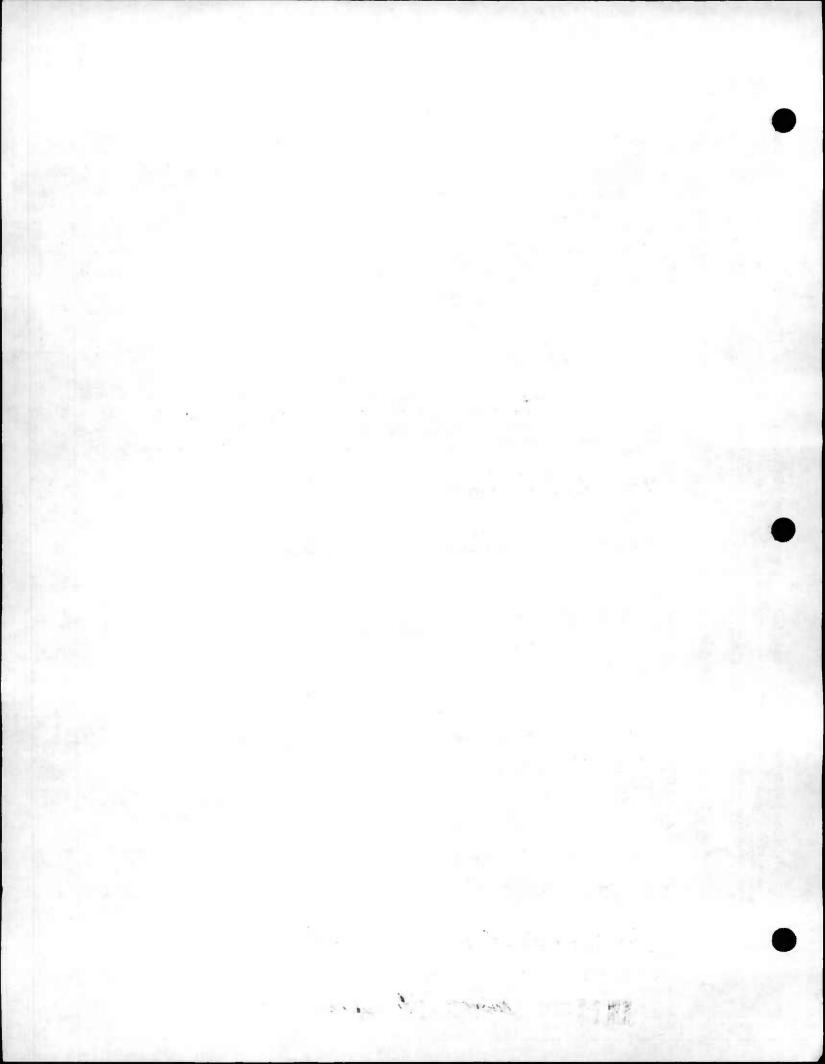
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/Medica	William	A. Buxton						25, 2000	
Examine			r)			4b. City, Town,	or Location of Deet	4c. County	of Deeth
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7 .	Usuet Residence of Decedent								
srylar show id at	10a. Stete 10b. County		10c. City, To	wn or Location					10d. Inside City Limits
the Ma 28s-f	Maryland Mont	gomery	Montg	omery V	illa	ge			1 ☐ Yes 2 1 No
or 28s-f	10e. Street and Number			10f.	Zip Code			10g. Citizen of V	Vhet Country?
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- A 44 A	1 Never Merried 2 ☑ Mar	Armed Forces					erto Rican, etc.)	Blac	k, Whita, atc.
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Maryland 21215-0020 62 should be filed within 72 hours at th and Mental Hygiens. 7 is marked other than "natural", or traumatic event, the Medical Exam To Re Compilated by	19e. Informent's Neme/Reletions						Rural Routa Numb		
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T Sap T	1 ☑ Burial 2 ☐ Cremetion 4 ☐ Donation 5 ☐ Other (5		Park1	awn Mem	oria	Park 6	130/2000	Doolers 1	le, Maryland
Saltimore, emit. Pages 1 ar appartment of Hea mportants if Item. iny Injury or other eice.	21. Signature of Funerel Service		Turki	22. Name	end Addra	ass of Facility			
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Physician									Onset and Death
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Examiner	resulting in death)	a. 1110		consequence		70////	C 4/1	· LL	1/12
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oxec n an ial-tr	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury		D00 (0 (0) as a	Consequence	л.				
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Atte of the state	3 Suicide 6 Could	not be 28e. Pleca of In	jury - At home, f	erm, street, fect	tory, office		28f. Location (Street end Numb	er or Rural Route Number,
Page 1	4 Homicide	building, e	(c. (Specify)				City or To	vn, Stete)	
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	Marlen	e J. Hac	ma	~ /	MD	3/36	2	June 26	, 2000
	30. Nema and addrass of person	who completed cause	death (Item 23a)			-,-			
	Marlene Haymar	U			0	deham-1	.wo W	11 00	077
	31. Dete filed (Month, Dey, Year)	32 Benist	rer's Signeture	ICK AVE	_{Ga}	rthersot	irg, Mary	rand_20	1877
Ctoto	,	Jan Broken							
State Registrar	JUN 9 D	2200	WAR THE STREET	160					



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent'a Name (First, Middle, Last) 2. Dete of Death Month 3, Time of Death Day Physician 25, ZUUL th | 4c. County of Death George H. Butler, 1:30 PM /Medical June 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 22200 Davis Mill Road Montgomery If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1XM 2□F Days Yes 218-24-1040
Usual Residence of Decedent Director Oct. 16, 1928 Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Maryland | Montgomery Germantown 10e Street and Number 10l. Zip Code 10g. Citizen of What Country? w 23a or 2 must be n 22200 Davis Mill Road 20876 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 ☐ No 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 72 hours after 1 Never Married 2K Married Maryland 21215-0020 M Yes, Give Year or Dates: 1951-53 1 Yes 2 No Specify: Specify: à 3 ☐ Wirlowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within 1 Department of Health and Mental Hyglene. Important: if them 27 is marked other than "n any injury or other treumetic event, the Man-Elementary/Secondary (0-12) College (1-4or 5+) Fruit Grower Orchard 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be George Henry Butler, Carrie Blue 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Todd H. Butler - Son 21900 Wildcat Road, Germantown, Maryland 20876 altimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Dete 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Salem Cemetery 6/29/2000 Germantown, Maryland 4 ☐ Donalton 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Trut L Olin L. Molesworth P.A., Funeral Home Mami 26401 Ridge Road, Damascus, Maryland 20872-0117 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or unant failure. List only one cause on each line. Approximete Interval Between Onset and Deetl **Physician** Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or es a conseque use as the buriel-transit or Attending Physician: The law requires that the death cartificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initioted events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760, Physician/Medicai Due to (or es a consequence of) cant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? has 250 No 1 Yes 1 ☐ Yes 2 ☐ No Division of Vital : After this certifical e funeral director, p 25. Was case a Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2010 t ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? Neturat 2 Accident 5 Pending investigation I after death.

I Director: After in by the fu 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 ☐ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide filled in To the Hospital o within 24 hours at To the Funeral Di completely filled li edical 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) end manner stated. 29a. Certifier (Check only 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) June 26, 2000 20886 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 19211 Montgomery Village Ave., Montgomery Village, Maryland Tibor E. Frekko, M.D. 31. Date filed (Month, Day, Year) 32 Pagistrar's Signature State Registrar

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 22202 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Month
June 23, 2000

A Death | 4c. County of Death **Physician** Glenn Franklin Bowers, Jr. 10:44 PM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner College View Nursing Center Frederick Frederick 8. Date of Birth (Month, Day, Year) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 1M M 2□ F 7. Age (In yrs. last birthday) **Funeral** Deys Yrs. Director 215-26-7750 Aug. 10, 1918 Maryland Usual Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director ms 23a or 28a-f Maryland Frederick Jefferson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3232 Jefferson Pike pemit. Papes 1 and 2 should be filed within 72 hours after death 1 Department of Health and Mental Hygiens. Important: If item 27 is marked other than "natural", or items 23a entry futury or other traumatic event, the Medical Examiner must once. 21755 USA 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indien 11. Marital Status Black, White, etc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ Yo Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) self welder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Glenn Franklin Bowers, Sr. Blanche Redmond 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Helen Bowers, wife 3232 Jefferson Pike, Jefferson, MD 21755

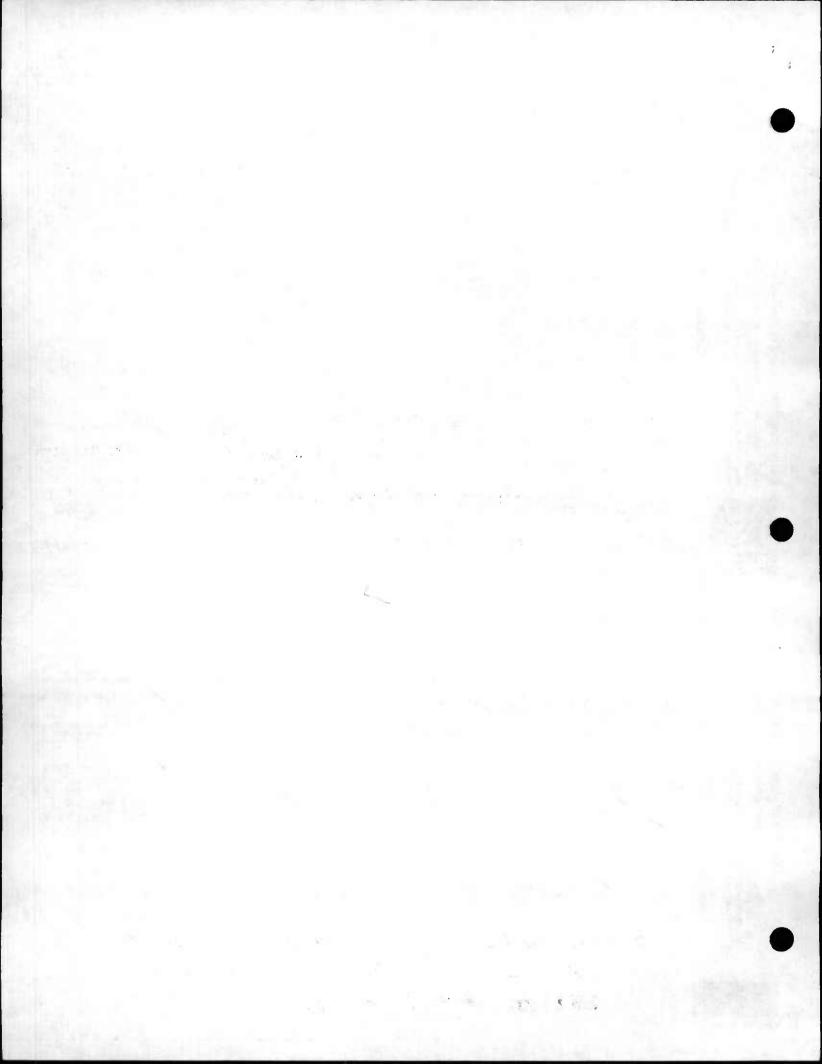
20b. Place of Disposition (Name of camelery, crematory or other place)

Date
6/27

20c. Location - City or Town, Stete Resthaven Memorial Gardens 2000 20a. Method of Disposition

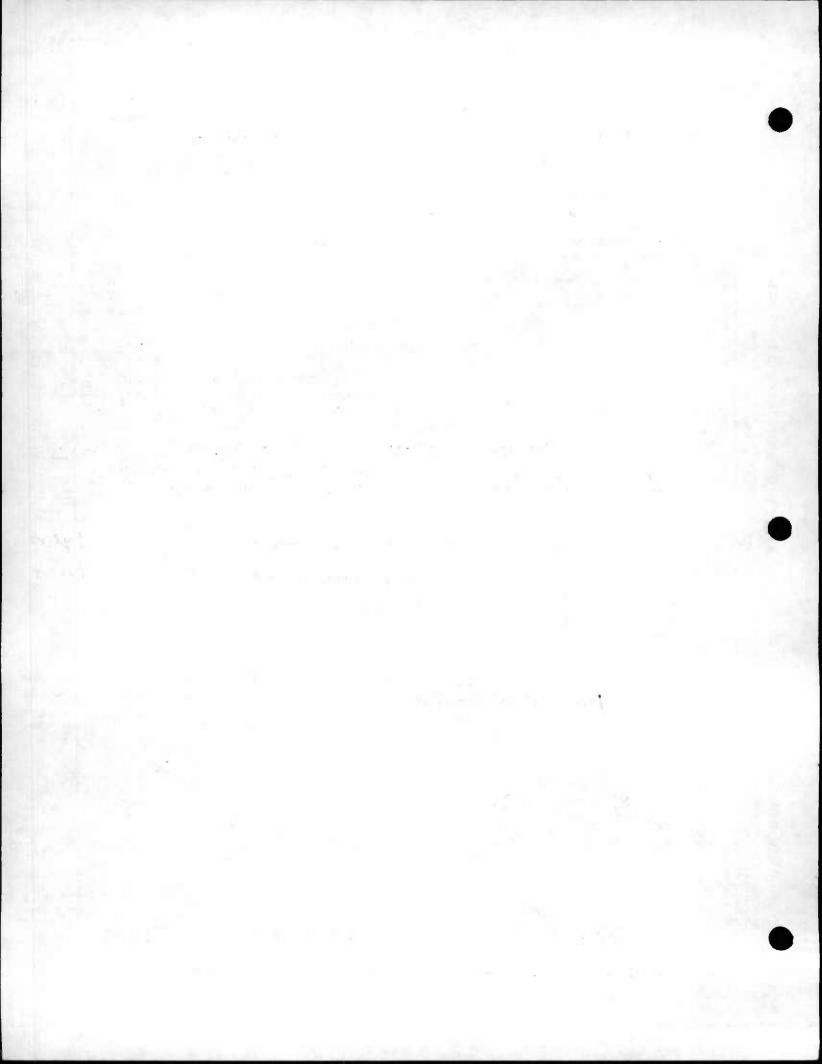
10 Burial 2 Cremation 3 Removal from State 4 Donation 5 DOther (Specify) Frederick, Maryland 21, Signature of Funeral Service Licens Keeney and Basford Funeral Home 23a. Part1. Enter the disease, or complications that based the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or healtr failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical MetaStatic Colon Cancer months Examiner Due to (or es a consequence of): Physician/Medical Examiner ettending physicien and for use as the burlel-transit or Attending Physicien: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Records, P.O. Box 68760. Due to (or es e consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Chronic atrial fibrillation To the Mospital or Attending Physicien: The law require within 24 hours elect deem, to To the Funarel Director: After this certificate has been sist completely filled in by the funeral director, page 2 should I 24b. Were autopsy lindings aveilable prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 1 Yes 2 1 No Division of Vital 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No edical Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Kathlen W Stern MS 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kathleen W Stem MD 610 Ninth ave 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2000 ▶ Registrar



State of Maryland / Department of Health and Mental Hygiene \(\) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** ROBERT BURDETTE BALDWIN July 2000 5:18 PM /Medical 4e Facility Neme (If not Institution, give street end number) 4b. City. Town, or Location of Death 4c. County of Deeth Examiner Fort Washington Fort Washington Hospital Prince Georges H Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year 5. Social Security Number 6. Sex 1X M 2□ F 7. Age (In yrs. lest birthday) Birthpiace (State or Foreign Country) **Funeral** Days Yrs. Director 218-05-5040 84 19,1915 Maryland August Usual Residence of Decedent 10s. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No Director Charles herra 23a or 28a-f iner must be notifie Bryans Road 10e. Street and Numbe 10f. Zip Code 20616 10g. Citizen of What Country? 6711 Amherest Road USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Bleck, White, etc. 11. Meritel Status filed within 72 hours after 1 □ Never Merried 2 □ Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: White Specify: 3 XWidowed 4 ☐ Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Mechanic Auto permit. Pages 1 and 2 should be file.
Department of Health, and Mental Hyg.
Important: If Item 27 is marked other any Injury or other trainment other obse. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Randolph Baldwin, Sr. Sadie Elliott Baldwin 19e. Informent's Name/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Edna L. McCoy/Daughter 2160Fairport Road Reedville, VA 22539 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Buriel 2 Cremetion 3 Removel Iron State
4 Donetion 5 Nother (Specify In Combment Trinity Memorial Gar. 7/6/00 Waldorf, Maryland 21. Signety of Funeral Service Licensee AREHART-ECHOLS FUNERAL HOME, P.A. 的00945 Cenus P.O. BOX 567 LA PLATA, MD. 20646 Approximete Intervet Between Onset and Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart teilure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical heart Examiner Physician/Medical Examiner after sician and burial-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury uence of): Stenons Box 68760. attending physician for use as the buria thet initiated events resulting in death) Last Due to (or es a consequence of) P.O. 1 Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? for lure 1 Yes 2 No 3 Probably 4 Unknown renal bengis Division of Vital Records. þ 24b. Were autopsy lindings aveilable prior to Be Completed 24a. Wes an eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician:
 24 hours after death.
 Funeral Director: After this certificalety filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 28 No 1 Inpatient 2 ER/Outpatient 3 DOA edical Certification: To Menner of Deeth 28e. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 1 Naturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, ferm, street, lectory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 4 Homicide To the Hospital or within 24 hours aft To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, end due to the cause(s) end menner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Certifier 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/3/00 DO042707 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) George Bren, M.D. 3600 Leonardtown Rd. Suite 103 Waldorf, MD 20601 31. Dete liled (Month, Day, Year) 32. Registrer's Signeture State JUL 0 5 2000 Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death Day Yaar Month **Physician** ANITA LOUISE BOBLETT 2000 10:25 AM UL /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner BALtimore LANA If Undar 1 Yeer if Undar 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, **Funeral** Days Year) FEBRUARY 26.1937 WEST VIRGINIA 235-52-0842 63 Yrs. Director Usuel Rasidenca of Decadant the Maryland 10e. Stata 10c. City, Town or Location 10d. Inside City Limits 10b. County 7 is marked other than "naturel", or Nems 23a or 28a-f show traumatic event, the Modical Examinar must be notified at 1 Yes 2X No Directo MARYLAND CHARLES WALDORF 10e. Street and Number 10f. Zip Coda 10g. Citizan of Whet Country? with 2502 LISA DRIVE 20601 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours eftar death v Department of Health end Mantel Hygiane. Important: If frem 27 ie marked other than "naturel", or Neme 23: any Injury or other traumatic event, the Modical Examples must Funeral 12. Was Decedant Ever in U,S. Armad Forcas? 1 ☐ Yas 2 [X] No If Yas, Giva Yaar or Datas: Was Decedant of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14 Bace - American Indian 11. Meritel Status Black, Whita, atc. 1 ☐ Navar Marriad 2 ☐ Married 1□ Yas 21 No Specify: Specify: WHITE b 3 Widowed 4 □ Divorced Completed 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT usa ratired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) Collaga (1-4or 5+) HOMEMAKER OWN HOME 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Meiden Sumama) Be JACK ARNOLD WOOTEN VERNA VICTORIA STONE 2 19a. informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) CINDY L. HARDY/DAUGHTER 13025 HICKORY AVE., WALDORF. MARYLAND 20b. Placa of Disposition (Nema of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremetion 3 ☐ Removel from Stete HUNTT CREMATORY 4 □ Dogation 5 □ Othar (Spacity) 7/7/2000 WALDORF, MARYLAND 21. Signatu Junaral Sarving Licensea 22. Name and Address of Fecility THE HUNTT FUNERAL HOME, INC., POST OFFICE BOX JPK JOHN P. KNISLEY M01164 156, WALDORF, MARYLAND 20604-0156 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Deeth Physician Immediata Causa (Final disease or condition rasulting in daath) /Medical Examiner Dua to (or as a consequence of) Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentielly list conditions, if eny, leading to immadiata causa. Entar Undarlying Causa (Diseasa or injury that initiated evants resulting in daath) Last Due to (or as a consequenca of) Physician/Medical ending physic r use as the t Dua to (or as a consequence of) for u signed by the a Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown þ 24b. Wera autopsy findings eveilable prior to completion of cause of death? been sig 24a. Wes an autopsy Completed performed? il diractor, pege 2 s 1 □ Yas 2 □ No 1 Yas 2 No Hospital or Attanding Physician: Be 25. Wes case refarred to medical 26. Placa of Death (Check only ona) axaminer? Othar: 4 Nursing Home 5 Residence 6 Othar (Spacify) 2 1 ☐ Yes 2 No 1 Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA After this 27. Mannar of Death 28c. Injury et Work? 28b. Tima of 28d. Dascribe how injury occurred Certification: 5 Pending Invastigation 1 Natural To the Hospital or Attandit within 24 hours after death. To the Funerel Director: Al completely filled in by the fu death. 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be datarmined 3 Suicida 28e. Pleca of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Numbar, City or Town, Stete) 4 ☐ Homicida

Records, P.O. Box 68760,

Division of Vital

31. Data filed (Month, Day, Year) JUL 0 5 2000 Registrar

29a. Certifier

30. Nama and

(Check only one)

29b. Signeture end titla of cartifiar

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edical

C 10 m,D 32. Registrar's Signatura Janens

address of person who completed cause of death (Item 23a) (Type, Print)

maryland

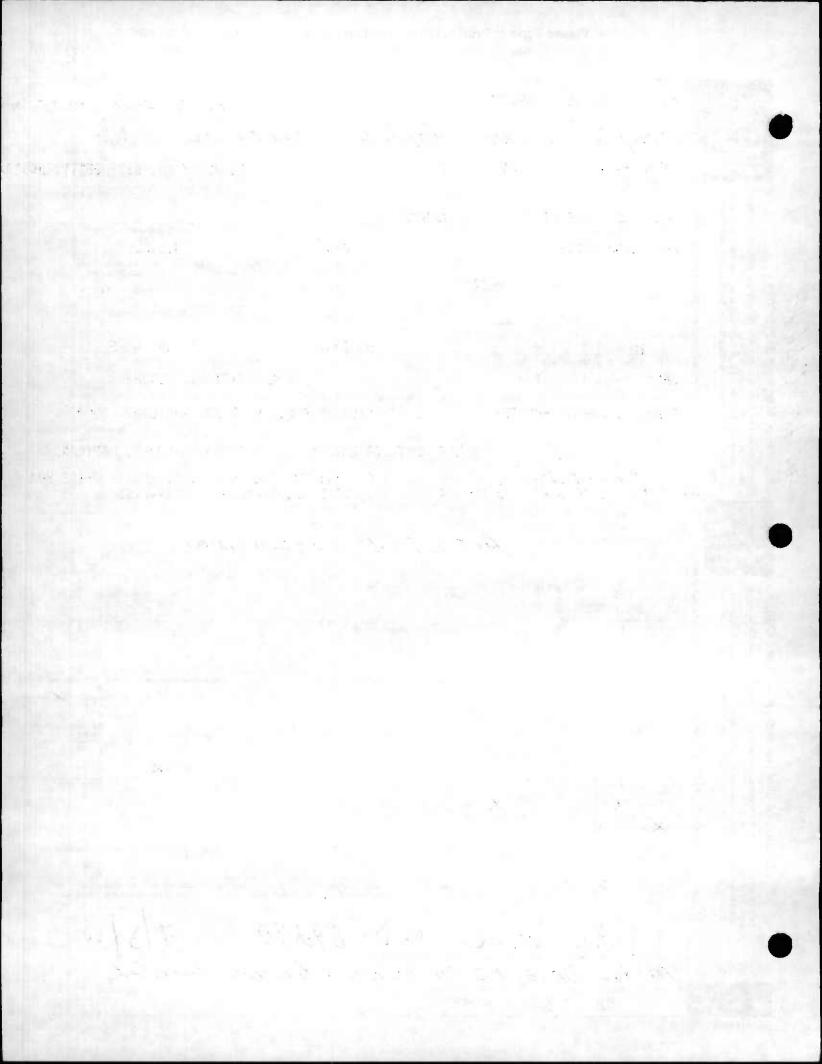
Certifying Physician: To the best of my knowledge, deeth occurred at tha tima, data and place, and due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the best of axamination and/or invastigation, in my opinion, daeth occurred at the time, date and place, and due to the causa(s) and mannar stated.

29c. Licanse number

29d. Date signed (Month, Day, Year)

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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22205 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Nama (First, Middla, Last) Month Day Year **Physician** 1:20 AM Mary Louise Baxter July 2000 /Medical 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiñer 2237 Sandalwood Drive Waldorf Charles 8. Dale of Birth (Month, Dey, Year)
Dec. 27,1932 Washington.DC If Under 1 Yaar | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours 10 M 2XX Montha Yrs. 577-44-2916 67 Director Usual Rasidence of Decedent the Meryland 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limita or items 23s or 28s-f show the Medical Examiner must be notified at Maryland Charles Cobb Island 1 Yas 2 No Director 10f Zin Code 10g. Citizan of What Country? 10e Street and Number death with 20672 U.S.A. 18226 Piedmont Drive Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status filed within 72 hours efter 1 ☐ Yes 2 No If Yes, Give 1 ☐ Nevar Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Yaar or Datas: "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grads completed) Prince George's County I Hygiene. Elemantary/Secondary (0-12) Coilege (1-4or 5+) Board of Education Bus Driver 11 other traumatic event, 18. Mother's Name (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) permit. Peges 1 and 2 should be file Department of Heelth and Mental Hy Important: if flam 27 is marked oth any Injury or other traumatic event Pables. Be Margaret Davis Charles Eugene Evans 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, Stete, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) Leon F. Baxter/Husband 18226 Piedmont Drive, Cobb Island, Maryland 20672 20b. Place of Disposition (Name of cemetery, cremetory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burlal 2 Cremation 3 Removal from State Upper Marlborn, MD 07-05-2000 St. Barnabas Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Filmeral San Actions see 22. Name and Address of Facility
The Huntt Funeral Home, Inc. JOHN P. KNISLEY M01164 P. O. Box 156, Waldorf, Maryland mew 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition rasulting in death) Renal Cell Cancer with metatasis to brain Examiner Dua to (or as a consequence of): Examiner attending physician and for use es the burial-transit The lew requires that the death certificeta be executed Sequentially list conditions, if any, leading to immadial a causa. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of) Box 68760 Physician/Medical that initialed avents resulting in death) Last Due to (or as a consequence of) P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? page 2 should be detached 1 Yss 2 No 3 Probably 4 Unknown signed by Division of Vital Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? After this certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes 🌪 No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifical completely filled in by the funeral director, 25. Was case referred to medical Certification: To Be 26. Place of Death (Check only one) at son's home Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca XXOther (Specify) 1 ☐ Yas XX No 27. Manner of Death 28b. Time of Injury 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 6 Could not be determined 3 ☐ Suicide 28a. Place of Injury - At home, farm, street, factory, office building, atc. (Specify) 4 Homicide The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number

State Registrar 31. Data filed (Month, Dey, Year)

JUL 0 5 2000

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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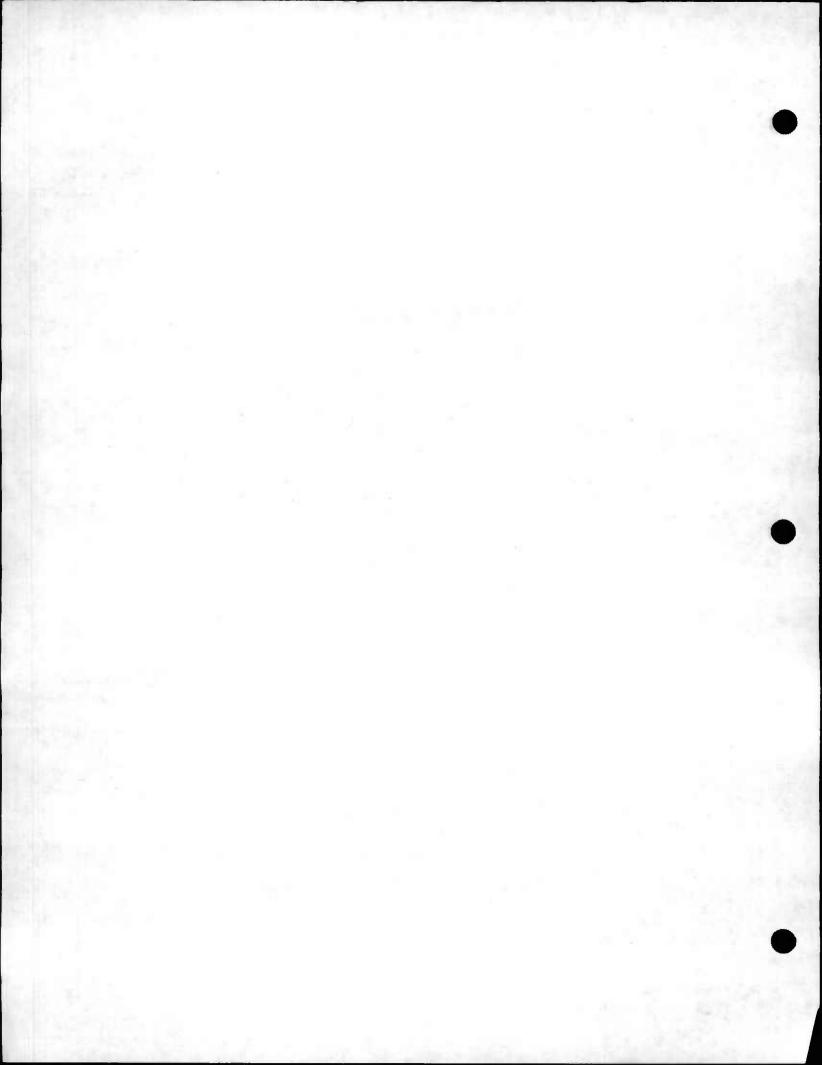
Krishan Mathur, MD., P.O. Box 1703, La Plata, MD

B. Sporker

D28352

July 3, 2000

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Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth Month Yee PHILLIP HERMAN BOND 2000 July 7:51 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Civista Medical Center LaPlata Charles 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, May 17 7. Age (In yrs. last birthdey) Deys Hours 1940 M 2DF Yrs. 60 578-52-5211 Washington, DC Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Waldorf 1 Yes 2 No Charles Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 USA 6730 Mink Court 12. Wes Decedent Ever in U,S. Armed Forcas? 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Merital Status 1 Never Merried 2 Merried 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Government Fireman 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Surneme) Ruby Gray Owens Unknown 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 6730 Mink Court Waldorf, MD 20603 <u> Irving W. Gray Jr (PRD)</u> 20a. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory 22. Name end Address of Fecility 7-4-00 Alexandria, VA 21. Signature of Fundral Service Licens Eberwein Funeral Services M00173 Mu 4433 White Pls la White Pls., MD 20695 23a. Park. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Deeth Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): arrance Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): SIS Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23b. Dfd tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown SCI 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy periormed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

ettending physician and for use as the burial-transit certificeta be axecuted Physician/Medical The lew requires that the death sate has been signed by the a page 2 should be detached to à Completed certificate Hospital or Attending Physician:
 24 hours aftar deeth.
 Funeral Director: After this certifical letsly filled in by the funeral director; g Be

P.O. Box 68760,

Division of Vital Records,

Physician

/Medical Examiner

Physician

/Medical

Examiner

Directo

Funeral

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Completed

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Funeral

Director

Demili. Pages 1 and 2 should be filed within 72 hours sher death with the Marylas Department of Health and Mental Hygiene. Important: If flem 27 is marked other than "netural", or hems 23s or 28s-f show any injury or other treumstic event, the Medical Examiner must be notified as

altimore, Maryland 21215-0020

25. Wes case referred to medical Hospitel: 1 ☐ Impatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 6 Other (Specify) 1 Yes 2 No 28a. Dete of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 2 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 - Homicide 15 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner steted. 29a. Certifier (Check only one)

29c. License number

D-46046

29d. Date signed (Month, Dey, Year)

State Registrar

completely

To the Within 2

Certification:

edical

29b. Signature and title of certifier

31. Date filed (Month, Day, Year) 5 2000

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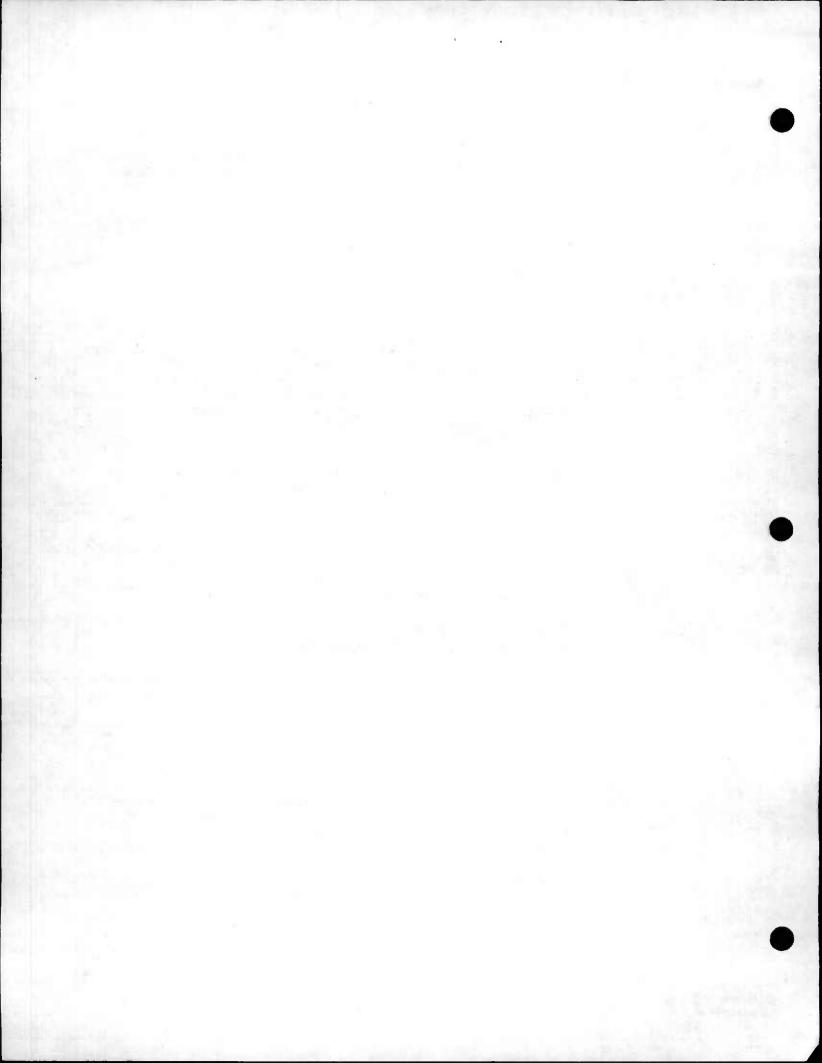
Amir A Mirza Alikhani, MD, FCCP 118 LaGrange Ave P.O. Box 1890 LaPlata MD 20646

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32. Registrer's Signeture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

	4 December 11 and 15 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 and 16 an		06		Death		leg. No.	2 Time of Dooth
Physician	Decedent's Neme (First, Middle, Last		180.4			2. Date of Dea Month	Dey Year	3. Time of Death
/Medical	SARAH	BARSTLEI	R 1	BUCHER		June	23, 2000	2:00AM
Examiner	4a Facility Nama (If not institution, give	street end number)			4b. City, Town, or Lo	cation of Death	4c. County of De	ath
	SALISBURY CENTER:	GENESIS ELD	ERCARE		SALISBURY,	MD	WICOMIC	0
Funeral	5. Social Security Number 6. Se		yrs. last birthday)	If Under 1 Yea		8. Dete of Birth (Month, Day	9. B	irthplace (State or Foreig
Director	199-14-6454 Usuel Residence of Decedent	⊒м 2⊠F 75	Yrs.	Months Days				ennsylvania
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the Mary 28a-f sh notified.	Maryland Worces	ter	Pocomo	ke City				1 Yas 2 XN
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	Due Cora	lo (or as a conse	quence of):	deser			days
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22208 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month **Physician** June 27, EUGENE L. 2000 2:20 P.M. CARROLL /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Prince George's MARINER HEALTH OF SOUTHERN MARYLAND Clinton
If Under 24 Hrs. 5. Social Security Number 8. Data of Birth (Month, Day, Year) July 21, 1902 9. Birthplace (State or Foreign Country) Wash., D.C. 6. Sax 7. Aga (In yrs. last birthday) **Funeral** Days Hours 10 M 20 F Yrs. 97 578-05-7663 Director Usuel Rasidence of Decedant - NOW 10b County 10c. City, Town or Location 10d. Inside City Limits other traumatic event, the Medical Exansiner must be notified at 1 √ Yes 2 □ No Funeral Director Maryland Prince George's Clinton or 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 9211 Stuart Lane 20735 United States or items 23a death 12. Was Decedant Evar in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Giva Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14 Baca - Amarican Indian 11 Marital Status Black, White, atc. African permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Examinations. 1 Navar Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify: American Be Completed by 3 X Widowed 4 Divorced Yaar or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elamantary/Secondery (0-12) Collega (1-4or 5+) Musician/Contractor 12th Self-Employed 17. Fathar's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Robert Carroll Christine Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Martin E. Carroll, Sr. - Son 2008 Jameson St., Temple Hills, MD 20748 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Olivet Cemetery 20c. Location - City or Town, Stata 20a. Method of Disposition 1 Burial 2 Cramation 3 Ramoval from Stata 7/3/2000 Washington, D.C. 4 ☐ Donetion 5 ☐ Other (Specify) 22. Nama and Addrass of Facility 21. Signeture of Funeral Service Licanse Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 23a. Part1. Inter the disaase, or complications that caused the death. Do not antar the mode of dying, such es cardiac or respiratory errest, shockly or heart feilure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** Immediata Causa (Final disaasa or condition rasulting in deeth) /Medical m **Examiner** Physician/Medical Examiner signed by the attending physician and id be detached for use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadieta cause. Enter Undarlying Cause (Disaase or injury that initiated evants rasulting in daath) Last Box 68760. Due to (or as a consequance of): P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Pert I. 23b. Did tobacco use pontribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records. þ 24b. Ware autopsy findings available prior to complation of cause of death? is certificate has been si director, page 2 should Completed 24e. Was an autopsy 1 Yes 2 No 1 ☐ Yas 2 ☐ No After this certificata Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica Be 25. Was casa referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Rasidence 6 Othar (Specify) 1 Yas /2 No P 1 Dinpatient 2 ER/Outpatient 3 DOA in by the funeral 27. Manger of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how Injury occurred Certification: 28b. Tima of 28c. Injury at Work? 1 Neturel 5 Panding invastigation 1 ☐ Yas 2 ☐ No 2 Accident 3 Suicida 6 Could not be 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28a. Placa of Injury - At home, farm, straat, factory, office building, atc. (Specify) 4 Homlcida 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and dua to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and dua to the cause(s) and manner stated. edical 29a. Certifier 29d. Data signad (Month, Day, Year) 29b. Signiture and title of certifian License number 30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

Laxmi N. Berwa, 7700 Old Branch Ave., Suite C-101, Clinton, MD 20735

DHMH 16 Rev 6/95

Registrar

31. Date filed (Month, Day, Year)

JUN 3 0 2000

32. Registrer's Signatura

Charte No. 34 - 2 99050 THUE

State of Maryland / Department of Health and Mental Hygiene 22209 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Month Dev **Physician** Harold 2:20 AM Chase /Medical June 25,2000 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Mariner Health of Greater Laurel Laure | Laure |

Mariner Health of Greater Laure | Laure |

Social Security Number | 6. Sex | 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | 8. Dale of Birth (Month, Dey, Year) |

Yrs. | Months | Days | Hours | Min. | Mar 21, 1 Examiner Prince Georges 5. Social Security Number Birthplece (Steta or Foreign Country) **Funeral** Virginia Director 1926 Usual Residence of Decedent 10a Stale 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director - 28a-1 Prince Georges Beltsville 10a. Sireet and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 5401 0del1 Road 238 20705 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 [X] Yes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Raca - American Indien, Bleck, White, etc. 11. Merital Stetus 72 hours after 1 Never Married 2 Merried ò Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If lern 27 is marked other than *s any fijury or other traumetic event; the Med Once. Elementary/Secondary (0-12) College (1-4or 5+) Store Manager US Gov't 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be Lorenzo Chase Eva Chivies 2 19e. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Loretta Chase 5 4 0 1 0 d e 1 1 R D , B e 1 t s v i 1 e M D 2 0 7 0 5 e of Disposition (Name of Dete 20c. Location - City or Town, Stete (Wife) 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery 7/1/2000 Alexandria Va. 22. Name and Address of Facility Greene Funeral Home Inc 21. Signetura of Funaral Service Licenses nely 814 FranklinST, Alexandria,VA 22314 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tellure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in death) MYUCARDIAC /Medicat INFARCTION ACUTE **Examiner** Due to (or es a consequence of) Physician/Medical Examiner sician and burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as e consequence of): Records, P.O. Box 68760, the Due to (or as a consequence of): for use as Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? sata has been signed by page 2 should be detac 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown CHRONIC RENAL FAILURE þ 24b. Were eulopsy lindings aveilable prior to complation of causa of death? Completed 24e. Wes an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ₺ No Division of Vitai or Attanding Physician: funeral director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of After 5 Pending investigation 1 Netural Hospital or Attanding 24 hours after death.
 Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident filled in by the 6 Could not be 3 ☐ Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Placa of Injury - At home, ferm, street, tactory, office building, etc. (Specify) 4 ☐ Hornicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29e. Certifier Medical within 24 hor To the Fune completely fi (Check only one) ŝ 29b. Signature and title of certifier 29c. License numbar 29d. Date signed (Month, Dey, Year) 024997 Mile 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nis CHEPLAY CALE CASAS MUREL MAD. 20707 8317 A.

DHMH 16 Rev 6/95

State Registrar

31. Dete filed (Month, Day, Year)
JUN 2 8 2000

32 Registrar's Signature

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DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22211 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Death June 25, Day **Physician** 2000 9:18PM Coffren Diana Lee /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton Southern Maryland Hospital If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year, 1949 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 27 F Washington DC Vis 258-15-8125 Director Usual Residence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 No 28a-f a Directo Maryland Prince George's Clinton 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 23a or U.S.A. 20735 8221 Golden Drive Funeral 12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Btack, Whita, etc. 11. Marital Status 72 hours after 1 Never Married 2 Namied 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: White b 1 Yes 2 No Specify: Baltimore, Maryland 21215-0020 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within: Department of health and Mersal Hygeros. Important: If Item 27 is marked other than "1 any injury or other treumetic event, the Med Elementary/Secondary (0-12) 7th College (1-4or 5+) N/A Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 8 Margaret Estell Reeves 2 William Talbert, Sr Demon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8221 Golden Drive Clinton, Maryland 20735 Robert E. Coffren, Sr. (Husband) 20b. Place of Disposition (Name of cometery, crematory or other place) June 29, 2000 20a. Method of Disposition 20c. Location - City or Town, State 1X Burial 2 Cremetion 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland State Veterans Cem. Cheltenham, Maryland 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD 20735 atte 23a. Part1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximate triterval Between Onset and Death **Physician** AREDNOMA of LUNG. /Medical Immediate Cause (Final disease or condition resulting in death) Examiner -4 MRB. NODES Examiner METASTOSO. do use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medicai Due to (or as a consequence of): signed by the attending. P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? X Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? page 2 N/A 1 ☐ Yes 2 ☐ No certificate of Vital 25. Was case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospital: Nopatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA this funeral 28a. Date of Injury (Month, Day Year) 27. Mepher of Death 28c. Injury et Work? 28d. Describe how injury occurred After Division or Attanding 5 Pending investigation To the Hospital or Attandit within 24 hours after death. To the Funeral Director: At 2 Accident 1 TYes 2 □ No 6 ☐ Could not be 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 ☐ Homicide

State

3. Registrar's Signature

on who completed cause of death (Item 23a) (Type, Print)

13 WATTER

Registrar

Medical

29a. Certifier (Check only

29b. Signature and title of certifier

W

Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) end manner as stated.

On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, dete and place, and due to the ceuse(s) and manner stated.

29c. License number

ALDORG. My

29d. Date signed (Month, Day, Year)

Santa Contract Mills

Cart Spire to the

DATE:

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 24a per phys. G787 9/5/00 yf Amended linel, fchd jd 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Day Year **Physician** Lois Vinginia Crompton 30 2:47pm 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 410 Birmingham Drive Frederick
If Under 24 Hrs. Frederick If Under 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 327-03-7225 84 Feb. 13, 1916 Illinois Director **Usual Residence of Decedant** Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland nent of Health end Mental Hygiene. 10a Stata 10b. County 10c. City, Town or Location 10d Inside City Limits Show other traumatic event, the Madical Examiner must be notified at Maryland Frederick Frederick 1 X Yes 2 No Funeral Director 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or hems 23s or 410 Birmingham Drive 21701 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Meritel Status Bleck, White, etc. 1 ☐ Never Married 2 ☐ Merried Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Be Completed by 3 X Widowed 4 □ Divorced White "natural" 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than any Injury or other traumatic event, the Me Etementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harold A. Dunsworth Beulah V. Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Steven Crompton (Son) 410 Birmingham Drive, Frederick, Maryland 21701 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Remova Smithsburg Crematory 6/1/00 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST., FREDERICK, MD 21701 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximete Intervat Batween Onsat and Daath **Physician** ASCVD /Medical tmmediata Causa (Finat diseese or condition rasulting in death) ears Examiner Dua to (or es e consaguença of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated evants resulting in deeth) Lest and Dua to (or es a consequence of) attending physician Box 68760 Physician/Medical the Due to (or as e consequenca of) 08n P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown of Vital Records, ģ 24b. Wera sutopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performed? 1 ☐ Yes 21 No 1 Yes 2 No After this certificate septal or Attending Physicien: Thours after death, nerel Director: After this certificati y filled in by the funeral director, pa 25. Was casa rafarred to medical examinar? Medical Certification: To Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Panding Investigation Injury 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di completely filled in 29a. Certifier 1 Certifying Physician: To the basi of my knowledga, daeth occurred at the lima, date and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and dua to the cause(s) and manner stated. 29b. Signature and title of cartifier 29d. Date signed (Month, Dey, Year) 29c. License number

State Registrar

Registrar JUN 0 6 2000

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31. Dete filed (Month, Day, Year)

30. Name and address of person who completed cause of

ORIGINAL

death (Item 23a) (Type, Print)

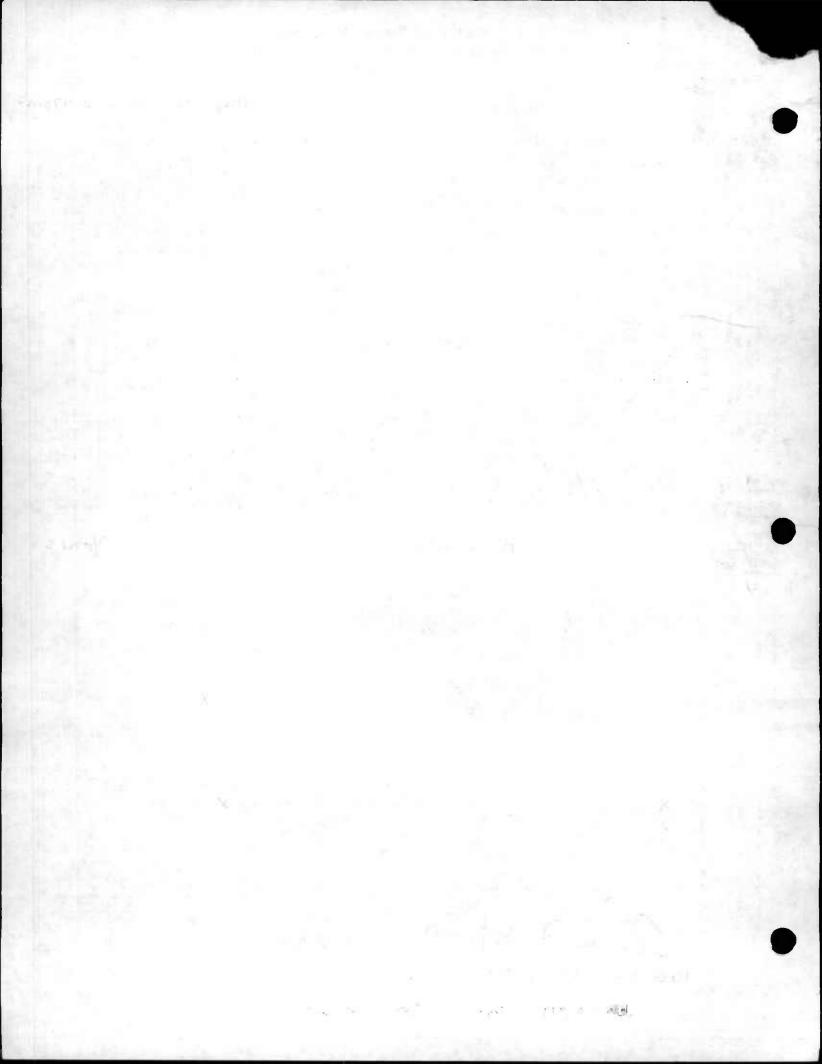
Frederick

SX

32. Registrer's Signeture

D35164

5/31/00



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer **Physician** VALARIE COOPER 27, 2000 JUNE 12:30am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner EASTON TALBOT TALBOT HOSPICE HOUSE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Deys Hours Months 1 □ M 2) F Yrs. Director MD. 36 212-86-0553 JUL.29,1963 Usual Residence of Deceden the Maryland permit. Pages 1 end 2 should be filed within 72 hours after death with the Marylan Department of Health and Mentel Hygiene. Important: If item 27 is marked other than "naturel", or Nems 23a or 28a-f show any fujury or other treumatic event, the Medical Examinat must be notified at once. 10a. State 10c. City, Town or Location 10d. Inside City Limits 1 X Yes 2 □ No Directo MD. TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Funeral 120 S. HIGGINS ST. 21601 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) Rece - American Indien, Bleck, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Maryland 21215-0020 If Yes, Give Year or Dates: 1□ Yes 2□No Specify: Specify: BLACK by 3 ☐ Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) NURSING ASSISTANT NURSING HOME 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be MELVIN CONWAY EMMA C. COLLINS 10 19a. Informant's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE BURKE/SISTER 404 SOUTH ST. EASTON, MD. 21601 Baltimore. 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) RICHARDSON CEMETERY 7/3/00 EASTON, MD. 21. Signature of Funeral Service License 22. Name and Address of Fecility DASHIELL FUNERAL SERVICES 319 E. DOVER ST. EASTON, MD. 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Deeth **Physician** Immediete Cause (Finel disease or condition resulting in death) /Medical (ancer Examiner Due to (or as a consequence of). Examiner the bunel-transit certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequenca of) physician ian/Medical Due to (or as e consequença of) USB BS Physicia P.O. signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed peen page 2 s has 1 Yes 2 TVN 1 ☐ Yes 2 ☐ No this certificate Division of Vital Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 2 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification: After 5 Pending investigation 1 PNatural Injury daath. 1 Yes 2 No 2 Accident after deat Director: 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 24 hours a 12 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) end manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end placa, and due to the cause(s) To the Hospi within 24 hou To the Funer completely fil 29a, Certifier edical end manner stated. 29d. Dete signed (Month, Day, Year) 29b. Storature and the of certifier 29c. License number 2 50 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DAVID SMITH MD 29466 PINTAIL DRIVE, EASTON, MD. 21601 31. Date filed (Month, Dey, Year) 32. Registraris Signature State

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Registrar

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Division of Vital Records,

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State Registrar 29a. Certified

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Registrar's Signature

and address of person who completed cause of death (Item 23a) (Type, Print)

111 Penn Street, Baltimore, Maryland 21201

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated.

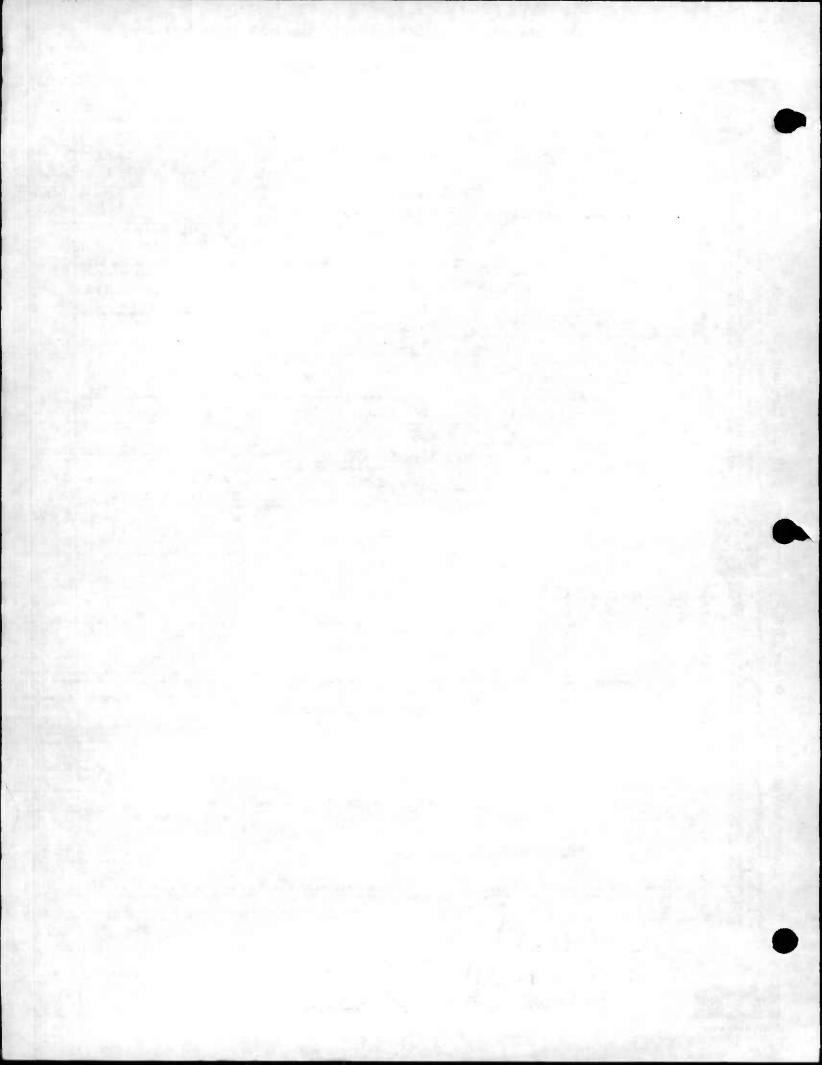
29c. License number

O.C.M.E

29d. Dete signed (Month, Day, Year)

28,2000

JUNE



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Dey Month Yee **Physician** Florence Jean Cairns 3:48 PM 2000 June /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4e Facility Neme (If not institution, give street end number) **Examiner** Montgomery General Hospital 01ney if Under 24 Hrs. Montgomery Birthplece (State or Foreign Country) If Under 1 Year 5. Societ Security Number 8. Dete of Birth (Month, Dey, Year) 7. Age (In yrs. lest birthday) **Funeral** Hours Months 1□M 2XF Deys Director 263-42-3328 70 Oct. 21, 1929 Maryland Usuel Residence of Decedent with the Meryland 10e. Stete 10b. County 10c. City, Town or Location 10d. inside Ctty Limits Show Itam 27 is marked other than "natural", or itams 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 1 Yes No Maryland Montgomery Damascus Director 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 10124 Lewis Drive 20872 U.S.A. Funeral Wes Decedent of Hispanto Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 11. Meritei Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hyglene. Important: If I tam 27 is marked other than "naturer" any Injury or other traumatic events. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Specify. 2 3 Widowed 4 Divorced White Completed 15. Decedent's Education (Specify only highest grede completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Bechtel Power Elementery/Secondery (0-12) College (1-4or 5+) 12 Secretary Corporation 17. Fether's Name (First, Middle, Lest) 18. Mother's Name (First, Middle, Maiden Sumeme) Be Jacob Lutz Bertha M. Plummer P 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 23456 19e. Informent's Neme/Reletionship (Type, Print) 4516 Rothwell Drive, Virginia Beach, Virginia ce of Disposition (Neme of Dete 20c. Location - City or Town, Stete Miriam R. Leech - Daughter 20e. Mathod of Disposition 20b. Place of Disposition (Name of cemetery, cremetory or other place) 1 ☑ Buriat 2 ☐ Cremetion 3 ☐ Removel from State Deer Park Cemetery 7/1/2000 Reisterstown, Maryland Other (Specify) 4 Donetic 21. Signature of Funera Service Licensee 22. Name end Address of Fecility Olin L. Molesworth P.A., Funeral Home overl 26401 Ridge Road, Damascus, Maryland 20872-011 23a. Pert1. Enlar the disease, or complications thet caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** /Medical immediate Cause (Final diseese or condition resulting in deeth) Examiner Due to (or es a consequence of): Examina MOCaRo the buriel-transit The law requires that the death certificete be executed Due to (or es e consequence of) pue Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury ettending physician for use es the burie Records, P.O. Box 68760 CORONARY **Physician/Medical** that initieted events resulting in death) Lest Due to (or es e consequence of) (nown 23b. Did tobacco use contribute to the causa of death? Pert il. Other significant conditione contributing to death but not resulting in the underlying cause given in Pert I. 2 No been signed by should be detec 3 Probably 4 Unknown þ 24b. Were eutopsy findings eveilable prior to completion of cause of deeth? Completed 24e. Was an autopsy pege 2 2 XNo 1 🗆 Yes 1 Yes certificete Division of Vital Hospital or Attending Physician: funeral director, 25. Wes case referred to medicat exeminer? Be 26. Plece of Deeth (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpetient 3 DOA 1 Inpatient Certification: To this 27. Menner of Deeth 28e. Dete of injury (Month, Dey 28b. Time of 28c. tnjury et Work? 28d. Describe how Injury occurred After 1 Natural 2 Accident 5 Pending injury efter death. Director: Aft 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 24 hours e Certifying Physician: To the best of my knowledge, death occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated. | Madical Examiner: On the basis of examination end/or investigetion, in my opinion, deeth occurred et the time, date end place, end due to the ceuse(s) and mention stated. 29a. Certifier Medical (Check only one) To the Vithin 2 29b Signature 29c. License number 29d. Date signed (Month, Dey, Year)

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MI 32. Registrer's Signature

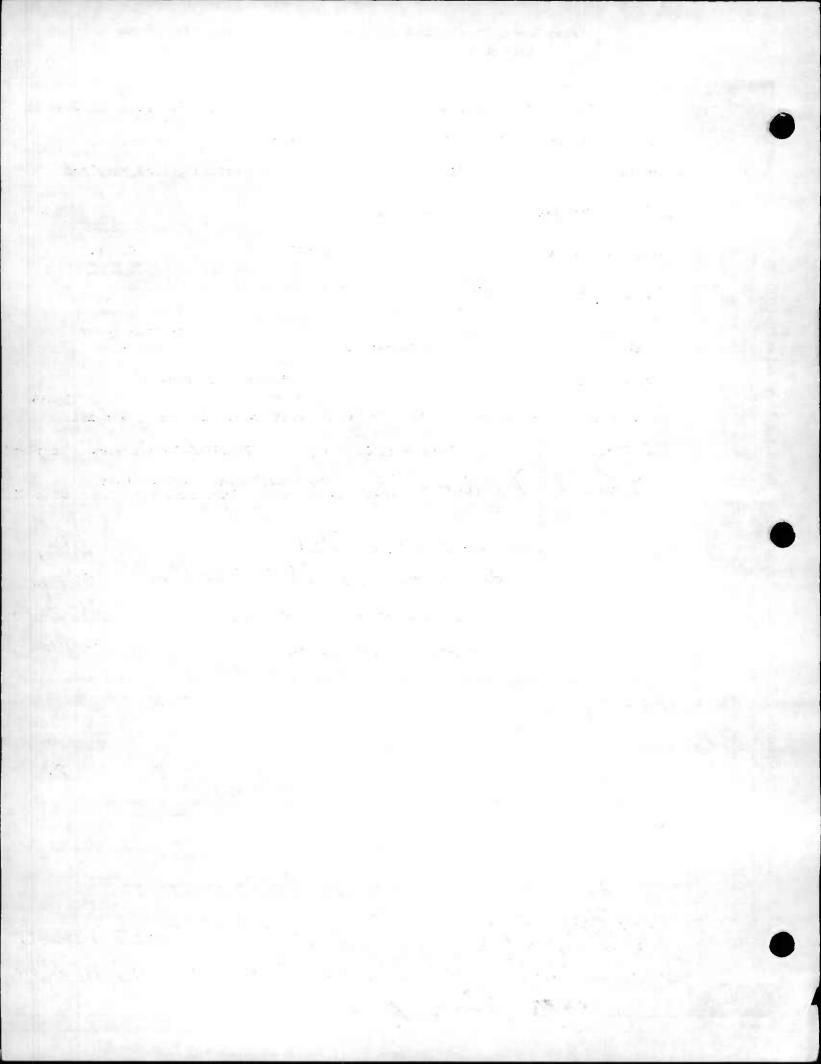
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PRINCE Phillip Dave Olney Maryland

State Registrar

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State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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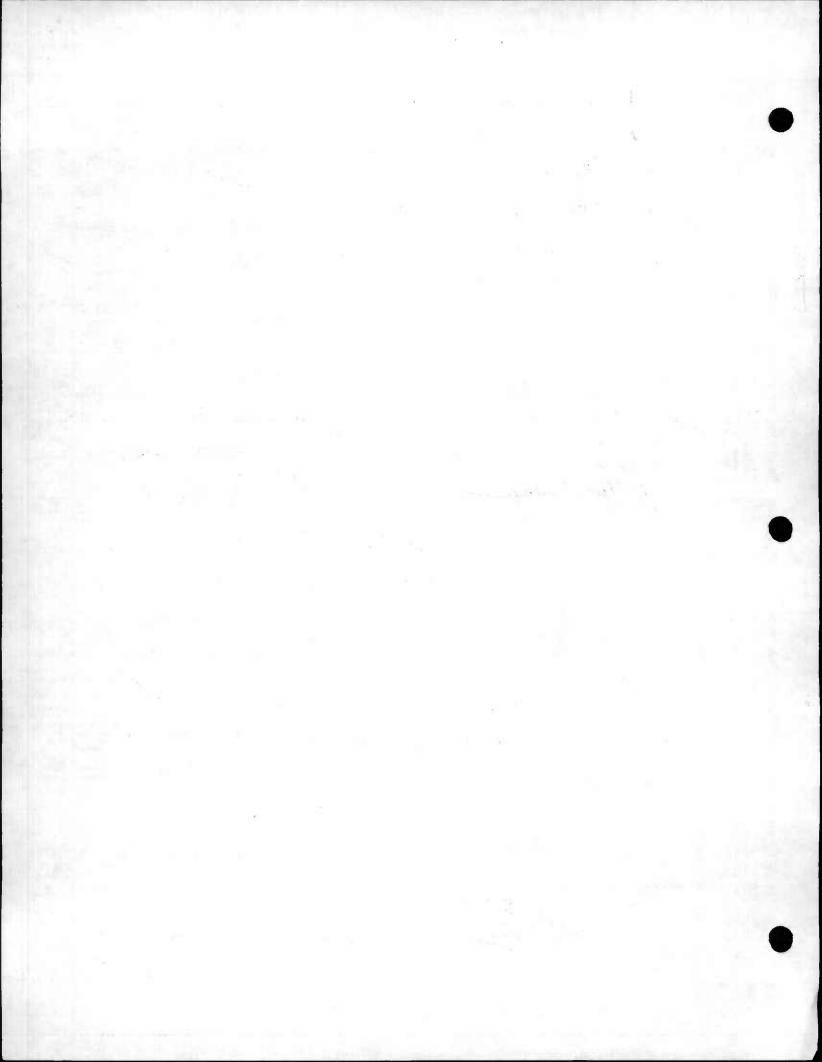
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State Registrar

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

muson Axon shyp CHR selbyville DE



Report of Party		(Certificate	e of Death		ental Hygie	. No.		22218
1. Decedent's Neme (First, Middle, Last	(1)		1100			2. Dete of Deeth Month	Dey	Year	3. Time of Death
Richard Denis I	24120					June 24	, 2000		10:00 am
la Facility Name (If not institution, give						cation of Deeth	4c. County		
3545 Madison Place		last hirtl	hday) If Under 1	-		7ille 8 Dete of Birth			eorge's
5. Social Security Number 6. Se	ex 7. Age ⊠M 2□F	79 Y		Days Hours	Min.	8. Dete of Birth (Month, Dey,) March 21,	'eer)	Cour	plece (State or Foreign ntry) eland
Usual Residence of Decedent						alcu,	1741	1.	erand
10a. Stete 10b. County		10c. City, Town	or Location						10d. Inside City Limits
	George's	Нуа	ttsville						1 ⊠ Yes 2 □ No
10e. Street and Number			10f. Zip (109	. Citizen of W		ntry?
3545 Madison Pla				20782	Tall.	212	U.S.A		
11. Meritai Stetus	12. Wes Decedent E Armed Forces?		13. Was Decede	ent of Hispenic Origi ify Cuban, Mexican,	jin? (Spec , Puerto P	cify Yes or No- licen, etc.)		e - Americ k, White,	etc.
1 Never Merried 2 Merried 3 ☑ Widowed 4 ☐ Divorced	1 ☐ Yes 2 📉 No If Yas, Give Yeer or Detes:	0	1□Yes 2	No Specify:			Specify	. Wh:	ite
15. Decedent's Edu	lucation	16a. [Decedent's Usuei	Occupation		16	6b. Kind of Bu	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
(Specify only highest grad	de completed) Coilege (1-4or 5-	((Give kind of work life. DO NOT use	k done during most of	of workin	g			
12	College (1 45. C.	+)	Railroa	d Agent			Rail	road	
17. Fether's Neme (First, Middle, Last)				18. Mother		(First, Middle, Ma		(e)	
Joseph Davis	12-6-21			Bri	idget	Whitt	Le		781.1
19e. Informent's Name/Reletionship (7)				(Street and Number				Stete, Zip	Code)
Maureen B. Rice -	Daughter			hua Lane,	, Bow		•	207	
20a. Method of Disposition 1 ☐ Burial 2 ② Cremetion 3 ☐ F		cemetery	Disposition (Nem-	her plece)	İ	300	c. Location -		
4 □ Donation 5 □ Other (Specify)	1	Metro				26/2000	Alexan	dria	, Virginia
21. Signeture of Funere Service License	196/	/1//		d Address of Fecility	1				
1 / / /	1.0		-25 CII 5	Funeral	ноте	P.A.			
Ma	Ulyne	1	4739 Ba	Funeral Itimore A	Avenu	ie, Hyat		e,MD	20781
23a. Part 1. Enter the disease, or complishock, or heart failure. List only o	lications that caused me cause on each line	the death. Do no	4739 Ba	ltimore A	Avenu	ie, Hyat		e,MD	Approximete Intervel Between
shock, or heert failure. List only o	plications that caused one cause on each line	the death. Do no	4739 Ba	ltimore A	Avenu	ie, Hyat		e,MD	Approximete
shock, or heert failure. List only o	one ceuse on eech line	NO.	4739 Ba	Iltimore A	Avenu	ie, Hyat			Approximete Intervel Between
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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.
To the Funeral Directors. After this certificate has been signed by the attending physician and completely filled in by the tunneral director, page 2 should be deteched for use as the buriel-transit completely filled in by the tunneral director, page 2 should be deteched for use as the buriel-transit Division of Vital Records, P.O. Box 68760,

Medical Certification: To Be Completed by Physician/Medical Examiner

Physician

/Medical

Examiner

To Be Completed by Funeral Director

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after

Physician /Medical

Examiner

Baltimore, Maryland 21215-0020

State Registrar

31. Dete filed (Month, Dey, Year)

JUN 2 7 2000

30. Neme and address of person who completed cause of death (New 23a) (Type, Print)
Leslie H. Pierce, Jr., M.D., 106 Irving Street, NW, #2500N, Washington, DC 32. Registrar's Signature

20010

A MANAGEMENT

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22219

					Certificat	e of	Death			Reg. No.		
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/a		Edward James D	ismuke				Jes	sie	Gund1	ing		
	SPEE	19a. Informant's Name/Ralationship	(Type, Print)	19b.	Mailing Addrass	(Street	and Numbe	r or Aura	Route Numb	er, City or Town,	State, Zip	Code)
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State of Maryland / Department of Health and Mental Hygiene 00 22220

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22221 Certificate of Death Reg. No 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** JUNE 22 Day **EMERSON** LAVINE DORSEY 8:17 AM /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Deeth Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK Social Security Number 218-16-1468 If Undar 24 Hrs 8. Date of Birth (Month, Dev. Year) MAY 11, 1922 7. Aga (In yrs. last birthday) If Undar 1 Yaar 9. Birthplace (State or Foreign **Funeral** Months Days Hours MD MD 10XM 2□ F 78 Yrs. Director Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits MD. FREDERICK FREDERICK 1 Yas 2 No Director 28a-f 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code 23a or 4812 TEEN BARNES RD. 21703 U.S.A. Funeral 12. Was Dacedant Ever in U,S. Agned Forces? 14≦ Yes 2 □ No ff Yas, Giva 1.9 43 – 46 Was Decedant of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Maxican, Puarto Rican, atc.) 14. Raca - Amarican Indian, Black, Whita, atc. BLACK permit. Pages 1 and 2 ahould be filed within 72 hours after Department of Health and Mental Hygiene. Important: if flom 27 is marked other than "netural", or lea any injury or other trainradic event the Marken E. 1 Never Merried 2 Merried Saltimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highast grada completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT usa retired) 16b. Kind of Business/Industry College (1-4or 5+) 4 YRS Elementery/Secondary (0-12) RESEARCH GOVT. MICROBIOLOGIST 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Be EDWARD DORSEY CARRIE DORSEY 10 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 19e. informant's Name/Relationship (Type, Print) EMERSON DORSEY, JR. 1104 PELHAMWOOD RD. BALT. MD. 21234 20b. Placa of Disposition (Name of 20c. Location - City or Town, Stata Date 20e. Mathod of Disposition RESTHAVEN MEM SCA, GAR. ₩ Burlai 2 Cramation 3 Ramovel from Steta JUNE 26 2000FRED MD 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signatura of Funarel Sarvice Licenses 22. Nama and Addrass of Facility GARY L. ROLLINS FUNERAL HOME olles 110 WEST SOUTH ST FREDERICK MD 21701 complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, only one cause on each line. Approximete intervei Between Onset end Deeth **Physician** /Medical immedieta Ceusa (Final disaase or condition rasulting in death) Examiner Examiner The law requires that the death certificate be executed the bunal-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Diseese or Injury that initiated avants resulting in death) Last Dua to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequence of) for use as P.O. Part fl. Other significant conditions contributing to death but not resulting in the underlying cause givan in Part I. 23b. Did tobacco use contribute to the cause of death? 1 108 2 No 3 Probably 4 Unknown Records, þ 24b. Wara autopsy findings available prior to complation of causa of death? 24e. Wes en eutopsy performed? Completed page 2 certificate has No No 1 Yas 1 Yes of Vital within 24 hours after death.

To the Funeral Director: After this certifical completely filled in by the funeral director, Hospital or Attending Physician: 25. Was casa referred to medical axaminer? Medical Certification: To Be 26. Place of Daath (Chack only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 20 No 1 Impatiant 2 ER/Outpatient 3 DOA 27. Menner of Deat 28a. Date of injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending invastigation 1 ☐ Yes 2 ☐ No 2 Accident 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 6 Could not be datarmined 3 Suicide 28a. Placa of Injury - At homa, farm, straat, factory, offica building, etc. (Specify) 4 Homicida Certifying Physician: To the best of my knowledge, deeth occurred at the time, data and place, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifian To the 29b. Signature and title of certifier 29c. License number 29d. Data signad (Month, Day, Year)

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FRED. MD 21701

32. Registrar Figniture

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PHILIP Shapiro

60

Registrar

State

30. Name end addrass of person who completed causa of daeth (Itam Z3a) (Type, Print)

2000 ▶

TOLL HOUSE AUC

31. Data filed (Month, Day, Year)

00-3464-031 UNKNOWN 00-161 SHAWN P. DEHAVEN

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e of Maryland / Department of Health and Mental Hygi	ene 00	22222
Certificate of Death	n No	

Physician /Medical **Examiner**

Shawn Patrick DeHaven 4a Facility Nama (If not Institution, give street end number)

1. Decedent'e Neme (First, Middle, Last)

JUNE 4b. City, Town, or Location of Death

2. Date of Death Month

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4c. County of Death

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Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

Baltimore, Maryland 21215-0020

Physician /Medical Examiner

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Division of Vital Records, P.O. Box 68760,

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30. Name and ad	dress of perso	on who completed	cause of death (It-	em 23a) (Type	e, Print)							

State Registrar

32. Registra s Signature

111 Penn Street, Baltimore, Maryland 21201

and red Gal

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

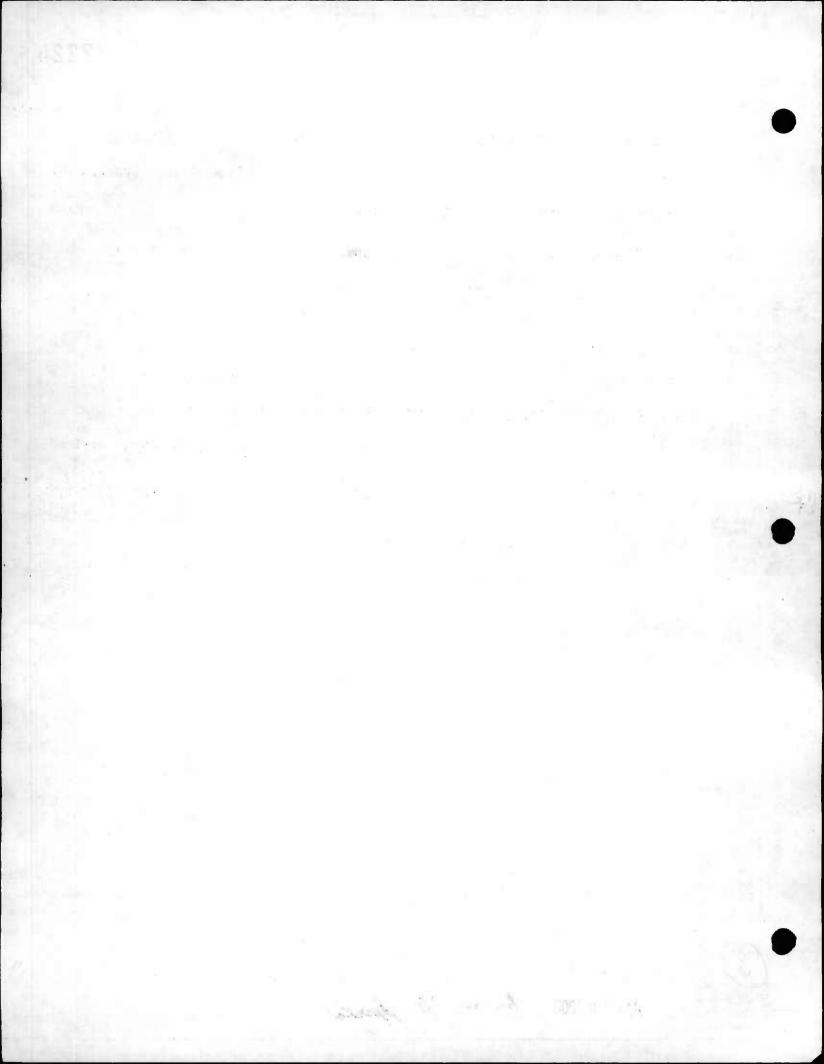
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DI		1. Decedent's Name (i	First, Middle, Last)							2	2. Dete of De Month	eth Dey	Year	3. Time of Deeti
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Section 1	xaminer	4e Facility Neme (If no	ot institution, give	street and number					4b. City, Tow	n, or Loca	ation of Deeth	4c. Coun	ty of Death	
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£ 8	ol ol	10e. Street and Number	er				10f. Z	ip Code				10g. Citizen o	Whet Coun	ntry?
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5-0020 72 hours after death with the Maryland	Examiner must be notified at by Funeral Director	11. Merital Stetus 1 Never Merried 3 Widowed 4	2 Merried	12. Wes Decedent Armed Forces 1 Yes 2 I If Yas, Give	7 No	S. 13	B. Wes Dec	edent of I ecify Cub	dispanic Origi an, Mexican, Specify:	n? (Speci Puerto Ri			ace - Americ eck, White, ify:	
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should be	ر م	William Kr	rug						Viola	Hug	hes			
and I	5	19a. Informant's Nemo	e/Retetionship (Ty	pe, Print)		19b. Me	iling Addre	ss (Street	end Number	or Rurel	Route Number	er, City or Tow	n, Steta, Zip	Code)
	5	Barbara Smi	th - Day	ohter		6712	Patte	reon	Stree	t R	iverda	le, MD	2073	3.7
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Division or Attending after death. Director: Atten	à =	3 ☐ Suicide 4 ☐ Homicida	6 Could not be detarmined	28e. Pleca of Ir	jury - At ho tc. (Specify	me, farm,	street, lacto	ory, office		28	of. Location (Street and Nur	nber or Rura	al Route Number,
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P	State		2.8.2000	6	-	1.	-							

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month Day BENJAMIN FRANKLIN FLUCKUS June 23 2000 5:52 AM 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 10211 Buena Vista Avenue Lanham Prince George's ff Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 6 Say 7. Age (In yrs. last birthday) Birthplaca (State or Foreign Country) Days Hours 100M 20 F 87 Yrs. 215-38-8993 Feb. 6, 1913 Georgia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1XYes 2 □ No Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 10211 Buena Vista Avenue U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien. Bleck, White, etc. 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Black Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 1 Year Elementary/Secondary (0-12) Chief Petty Officer Government 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Fluckus Elizabeth Gohan 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Claudette Fluckus/Wife 10211 Buena Vista Avenue, Lanham, Maryland 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ⊠Buriat 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Ceme. 2000 Arlington, Virginia 22. Name and Address of Facility
J. B.JENKINS FUNERAL HOME
7474 Landover Road, Landover, Maryland 20785 21. Signature of Funeral Service Licenses enc 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or hear failure. List only one cause on each line. Approximata Intervel Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic Prostate Cancer 5 Years Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown

Physician /Medical Examiner

Physician

/Medical

Examiner

10a. State

11 Marital Status

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Funeral

Director

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death

Director

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7 is marked other than "natural", or Nems 23s or 28s-f show traumatic avent, the Medical Examiner must be notified at

e filed within 72 hours after of Hygiene.

other than "natural", or her

permit. Pages i and 2 should be file Department of Health and Mentel Hy, Important: If flam 27 is marked othe any injury or other traumatic avant, plas.

Baitlmore, Maryland 21215-0020

The lew requires that the death certificate be executed

P.O. Box 68760,

Records,

Division of Vitai Attanding Physician:

Examiner Physician/Medical þ Completed 8

Certification: To

physicien and s the burial-transit 8 been signed by the a should be detached pega 2 s director,

certificeta

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After

deeth.

e Hospital or Attandil n 24 hours after deeth. e Funeral Director: A bietely filled in by the fo edical To the Hosp within 24 ho To the Fune completely fi State

Registrar

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2 No

27. Manner of Death

1 Netural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

(Check only one)

25. Was case referred to medical 26. Place of Deeth (Check only one)

Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 28a. Date of Injury (Month, Day Year) 28b. Time of

5 Pending investigation 6 Could not be

28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify)

STAFFE

Other: 4☐ Nursing Home 5 🖾 Residence 6 ☐ Other (Specify) 28c. Injury at Work? 1 Yes 2 No

#18870

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Dete signed (Month, Day, Year) 29c. License number

24a. Was an autopsy performed?

1 ☐ Yes 2 XNo

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

June 23, 2000

24b. Were autopsy findings available prior to

completion of causa of deeth?

1 Yas 2 No

UM, CUB PHYSICIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

John M. Hill, MD, National Nanal Medical Center, Bethesda, Maryland

31. Date filed (Month, Day, Year) JUN 2 6 2000

29b. Signature and title of certified

32. Registrar's Signature,

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22227 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Day Year Month **Physician** WALTER 4b. City, Town, or Location of Death 4c. 2000 /Medical FIELDS 03:43AM 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Prince Frederick Calvert Memorial Hospital Calvert If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 6. Sax 1 M 2 □ F 7. Aga (In yrs. last birthday) Birthplace (Steta or Foreign Country) **Funeral** Months 74 Yes 216-20-8319 Director Oct. 31, 1925 Maryland Usual Rasidanca of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yas 2 No Owings 28a-1 Director Maryland Calvert 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 8780 Grovers Turn Lane 20736 IISA Funeral 12. Was Decedent Evar in U,S. Armed Forcas? 13. Wes Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiens. Impoctant: If Hean 27 is merked other train "natural", or ther any injury or other traumatic event. the Modern 1 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Navar Married 2K Married Saltimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Custodian Board of Education 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maiden Sumama) Thorton Fields Margaret Robinson 19a. Informent's Neme/Ratationshtp (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Owings, MD 20736 Bertha Fields/Wife P.O. Box 678 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stafa 1 N Burial 2 □ Cremation 3 □ Removat from Stata 4 □ Donation 5 □ Othar (Specify) Calvary United Apost. Chr. 7/5/00 Sunderland, MD 22. Nama end Addrass of Facility Sewell Funeral Home 21. Signatura of Funaral Sarvice Licenses Surel 1451 Dares Beach Rd. Prince Frederick, MD 20678 23a. Pert1. Enter the disaasa, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximata tnterval Between Onset and Death **Physician** /Medical tmmediete Ceuse (Final disaasa or condition rasulting tn death) Cardio-Desp Examiner Dua to (or as a consequence of): Physician/Medical Examiner aspiration for use as the burial-transit Sequentially list conditions, if any, laading to immadiata causa. Entar Undarlying Cause (Disease or Injury that initiated avents rasulting in daath) Last Due to (or es a consequence of): P.O. Box 68760. CVA stroke Massin Dua to (or as a consequence of) DM Part II. Other algnificant conditions contributing to death but not resulting in the underlying causa given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Hospital or Attending Physician: The law requires that the death certificate be executed certificate this After 24 hours after death. Funeral Director: Af completely filled in by the

Be Completed by

Medical Certification: To

Records,

Division of Vital

HYN 24a. Was an autopsy 2 No 1 Yes 25. Was casa rafarred to medical axaminar? 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 28c. tnjury at Work? 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 1 Netural 5 Panding invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 3 Suicide 28a. Place of Injury - At homa, farm, straat, factory, office building, atc. (Specify) 4 Homicida

29e. Cartifiar (Check only one)

MD

29c. Licanse number

1 Certifying Physician: To the best of my knowledga, daath occurred at tha tima, date and place, and due to the cause(s) and menner as stated.

| Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to tha cause(s) and mannar stated.

29d. Data signed (Month, Day, Year)

24b. Ware autopsy findings available prior to completion of cause of death?

1 Yes 20 No

29b. Signatura and title of certifiar D 50290

7-1-00

30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

110 HOSPITAL RD PRINCE FREDERICK 20678 DHIREN SHAH, M.D. JUL 03 2000 -

State Registrar

To the P within 2

waste to make the

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Dev David Wayne Frye June 29,2000 10:38 A.M. 4c. County of Deeth 4a Facility Neme (If not institution, give street and number, 4b. City, Town, or Location of Death Frederick Memorial Hospital
al Security Number 6. Sex 7. Age (In yrs. last birthdey) Frederick 11 Under 24 Hrs. 8. Frederick

9. Birthplece (State or Foreign Country) If Under 1 Year 5. Social Security Number Dete of Birth (Month, Dey, Year) Deys Months Hours 17 M 2□ F 45 212-62-3060 June 6, 1955 West Virginia Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Frederick Frederick 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 119 S. Jefferson Street 21701 USA 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Rece - American Indien, Bleck, White, etc. 1 Never Merried 2 ☐ Merried 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes 2 No Specify Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Etementery/Secondary (0-12) College (1-4or 5+) Truck Driver Cement Company 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Roy Junior Frye Doris Lorraine Kroushour 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Doris L. Frye - Mother - Frederick, MD 21701
Dete | 20c. Location - City or Town, State 20b. Plece of Disposition (Name of cemetery, cremetory or other place) Jefferson St. 20a. Method of Disposition 1 X Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Fairview Lutheran Cemetery 7/3/2000 Bolivar, WV 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eackles-Spencer Funeral Home Ferry W 23a. Part1. Enter the disease, or complications that caused the deeth. shock, or heart feiture. List only one cause on each tine. Approximete Intervat Between Onset and Death Immediate Ceuse (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last e to (or es a consequence of): Pert th Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings eveileble prior to completion of cause of death? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No

Physician /Medical Examiner

Department of Important: If any Injury or

Physician

Examiner

Funeral

Director

Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23s or 28s-1 show ury or other traumetic event, the Medical Examinat mass by notified at

Baltimore, Maryland 21215-0020

Box 68760

P.O.

of Vital Records,

Division

The law requires that the death certificate be

or Attending Physician:

After this

/Medical

10e. Stete

Md.

Funeral Director

Completed by

Be 2

Examiner Physician/Medical Completed by

burial-transit the for usa as be detached Medicai Certification: To Be funeral To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After To the Funeral Director: After To the Funeral Director.

25. Wes cese referred to medicat examiner? 1□Yes 2□No

29e. Certifier

27. Manner of Death 5 Pending investigation 2 Accident 3 ☐ Suicide

29b. Signeture and title of certifier

31 Date filed (Month, Dey, Year)

6 Could not be determined 4 T Homicide

28a. Dete of Injury (Month, Dey Year) 28e. Plece of Injury - Al home, larm, street, lactory, office building, etc. (Specify)

32. Registrer's Signetu

1 Inpatient

2 ER/Outpatient 3 DOA

28b. Time of

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at Work? 1 Yes 2 No

29c. License number

1/2 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the besis of exeminetion and/or investigation, in my opinion, death occurred et the time, date end plece, end due to the ceuse(s) end manner steted.

28d. Describe how injury occurred

Name and gdd completed ceuse of deeth (Item 23e) (Type, Print)

2000

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Hospitel:

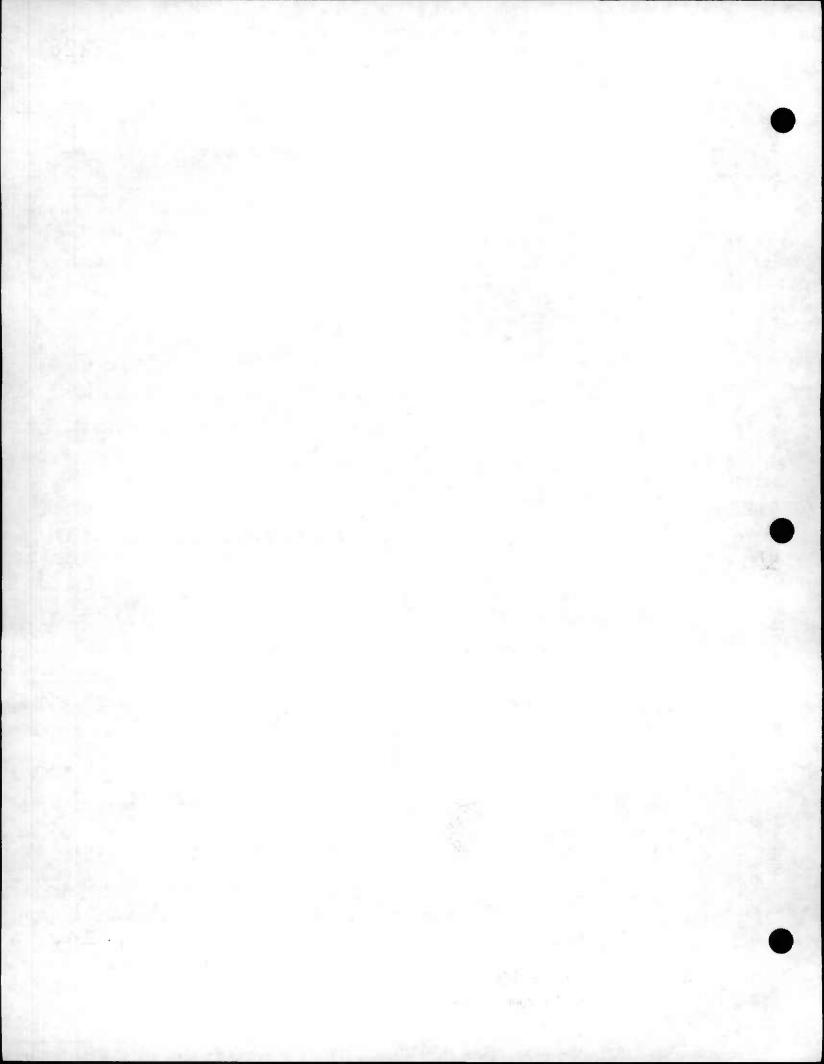
26. Piace of Deeth (Check only one)

2000 21702

29d. Date signed (Month, Day, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22220

			C	Certificate of	Death	R	eg. No.	1 44449
Physician	Decedent's Nama (First, Middle DONNA LISA BE)					2. Date of Deal		3. Tima of Death 9:00pm
/Medical Examiner	4a Facility Nama (If not institution DOCTORS HOSP				4b. City, Town, or LANHAM	Location of Death	4c. County of PRINCE	
Funeral Director	5. Social Security Number 042 48 5240 Usual Rasidance of Dacedant	·	a (In yrs. lest birtho 41 Yrs	Months Day		. (Month, Day		9. Birthplaca (Stata or Foraign Country) RIDGEPORT CON
Maryland la-f ahow the date	10a. Steta 10b. County	E GEORGES	10c. City, Town of UPPER	MARLBORO				10d. Insida City Limits 1 X Yas 2 □ No
ifter death with the Mainter death with the Mainter meet be notified. Funeral Director	10e. Street and Number 76 JOYCETON W	AY		10f. Zip Code 207			0g. Citizen of Wh	
by by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give		13. Was Decedent of If Yas, specify Cu 1 ☐ Yas 2 🟋 No	ban, Maxicen, Puar	Specify Yas or No- to Ricen, atc.)		- Amarican Indian, Whita, atc. BLACK
G 1 3	15. Deceder (Specify only highs Elamentary/Secondary (0-12)	nt'a Educetion st grada completed)	(C	ecedant's Usual Occ Giva kind of work don fe. DO NOT use reti	a during most of wo red)	orking	16b. Kind of Busi	
# T 8 0	CART W RENT	Last)		ACCOUNTAN	18. Mothar's Na	ma (First, Middla, I	PRIVAT	
d 2 should h and Mer 7 is marke traumatic	19e. Informent's Name/Reletions ROY V. GRAY			Tailing Address (Stree	et end Number or R	ural Routa Number		tata, Zip Code)
of He	20a. Mathod of Disposition 1 Buriel 2 Cremation 4 Donation 5 Other (S		cematary,	isposition (Nama of crametory or other p ECTION CEM	aca) ETERY	Date 6/29/00	20c. Location - C	City or Town, Stata MD •
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22230 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death June 22, 2000 **Physician** June V. Gallahan 8:10AM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e Facility Name (If not institution, give street end number) Examiner Southern Maryland Hospital Center Clinton Prince George's If Under 1 Year If Under 24 Hrs. Norths Days Hours Min. Super 16, 1924 9. Birthplace (State or Foreign Country)
Arlington, Mass. 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🂢 F Yrs 033-18-4249 76 **Director** Usuel Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes XX No Prince George's Maryland Clinton Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? 6 Hems 23s 12323 Piscataway Road 20735 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Bleck, White, etc. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiens. Important: If flem 27 is nervived other than "natural", or ite any injury or other traumetic event. the Mantral Ferrin 1XXYes 2 No WWII
If Yes, Give
Yeer or Detes: 1 Never Merried 2 Married Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: White 3√Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Board of Ed.P.G. Co. Asst. Lot Foreman 12th 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) Robert Henderson Little Mechtilde Veronica Donovan 19a. informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Gallahan/Son 13105 Larkhall Circle Ft. Washington, Md. 20744 Baltimore, 20a. Method of Disposition 20b. Piece of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State St. Mary's Church Cem.6/26/2000 Clinton, Md. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility George P. Kalas Funeral Home, P.A. alio 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 234. Perty. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one gause on each line. Approximete Interval Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical wecks Corelvaranculur **Examiner** Due to (or as a consequence of): Physician/Medical Examiner mobred vale Prosthetic y com Attending Physician: The law requires that the death certificate be executed use as the burial-tran Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting in death) Lest pue Due to (or as e consequence of) atrial Melmilation chronic Due to (or es a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? s been signed by t should be detech 1 Yes 2 No 3 Probably 4 Unknown Àq Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No certificate 1 Yes 2 No funeral director, Be 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Neturel 5 Pending death. 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

P.O. Box 68760, Records, Division of Vital

To the Hospital or Attendiff within 24 hours after death.
To the Funeral Director: All completely filled in by the fu edicai 15

State

Registrar

29b. Signeture end title of certifier Zery 29c. License number D13072

1XXCertifying Physician: To the best of my knowledge, deeth occurred et the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) end menner stated. 29d. Date signed (Month, Dey, Year) 6-22-00

30. Name and address of person who completed cause of deeth (ftem 23a) (Type, Print)

GurbuxNachnani, M.D. 8926 Woodyard Rd. Clinton, Md. 20735 31. Date filed (Month, Dev. Year

4 ☐ Homicide

(Check only one)

29a. Certifier

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State of Maryland / Department of Health and Mental Hygiene 00

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	Physicia	an	Decedent's Name (First, Middle							2. Date of De Month	Dev	Year	3. Time of Death
	/Medic		ERIC JACK GA	INOUS							2000		10:57PM
	Examin	- 1	4a Facility Neme (If not institution	n, give street end number)				4b. City, Town, or	Location of Deet	h 4c. Count	of Death	
			Doctors Hospit	al					Lanham		Princ	e Geo	rges
	Funeral Director		5. Sociel Security Number 578-70-8721	6. Sex 1∑ M 2□ F	ga (in yrs. last t		If Under Months	1 Year Days	If Under 24 Hrs Hours Min		th by, Year) 0-52	9. Birthe Cour Wash	pleca (State or Foreign ntry) nington D.C.
	/land		Usual Residence of Decedant 10a. State 10b. County		10c. City, To	wn or Loca	ation					1	10d. Inside City Limits
	Man	ō	Maryland Prince	Georges	Clin	ton							1₺ Yes 2 No
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21215-0020	s 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mentai Hygiena. Them 27 is marked other than "natural", or flema 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	þ	1 Never Merried 2 Man 3 Wildowed 4 Divorced		No				Specify:	to Moan, etc.)	Specia	ck, White, by: B1	Lack
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22233 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Day **Physician** June 25, 2000 Robert В. Ganey 7:05 AM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Mariners Health Care Silver Spring Montgomery If Under 1 Yaar | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) Nov. 3, 1928 5. Social Security Number 9. Birthplaca (Stata or Foreign Country)
Washington, D.C 7. Age (In yrs. last birthday) **Funeral** Days 100 M 20 F Yrs. 578-34-8974 Director **Usual Residence of Decedent** permit. Pages 1 and 2 should be liled within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Madical Examples mars be notified at once. 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1√Yas 2□No Director Maryland Prince Georges Hyattsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4922 40th. Place 20781 U.S.A. Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Giva Year or Dates: 1947 Baitimore, Maryland 21215-0020 1 ☐ Yas 2 ☐ No Specify: Specify: White 3 ☐ Wirlowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 11 0 Construction Engineer Tri-County Industries 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) Be Lee Ganey Inez Banta 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jacqueline L. Ganey (Wife) 4922 40th. Place Hyattsville, MD 20781 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Data 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Fort Lincoln Cemtery 6/28/00 Brentwood, Maryland 21. Signature of cheral Service Licens 22. Nama and Addrass of Facility
Rendon/Hale Funeral Home 9013 Annapolis Rd. Lanham, Maryland 20706 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, cause on each line. Approximata Intarval Batween Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Pneumonia 1-Month Examiner Dua to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physician and stall filled in by the funeral director, page 2 should be detached for use as the burial-transit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 XUnknown Cerebrovascular Disease Records, þ Be Completed 24b. Ware autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 1 ☐ Yas 2 No 1 Yas 2 No Division of Vital 25. Was case referred to medical axaminer? 28. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) 1 Yas 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28d. Dascribe how injury occurred 28b. Tima of 28c. Injury at Work? 1 D(Natural 5 Pending investigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital or within 24 hours after To the Funeral Dir completely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29b. Signature and title of certifie 29c. License number 29d. Data signed (Month, Day, Year) D09834 June 26, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 16 Rev 6/95

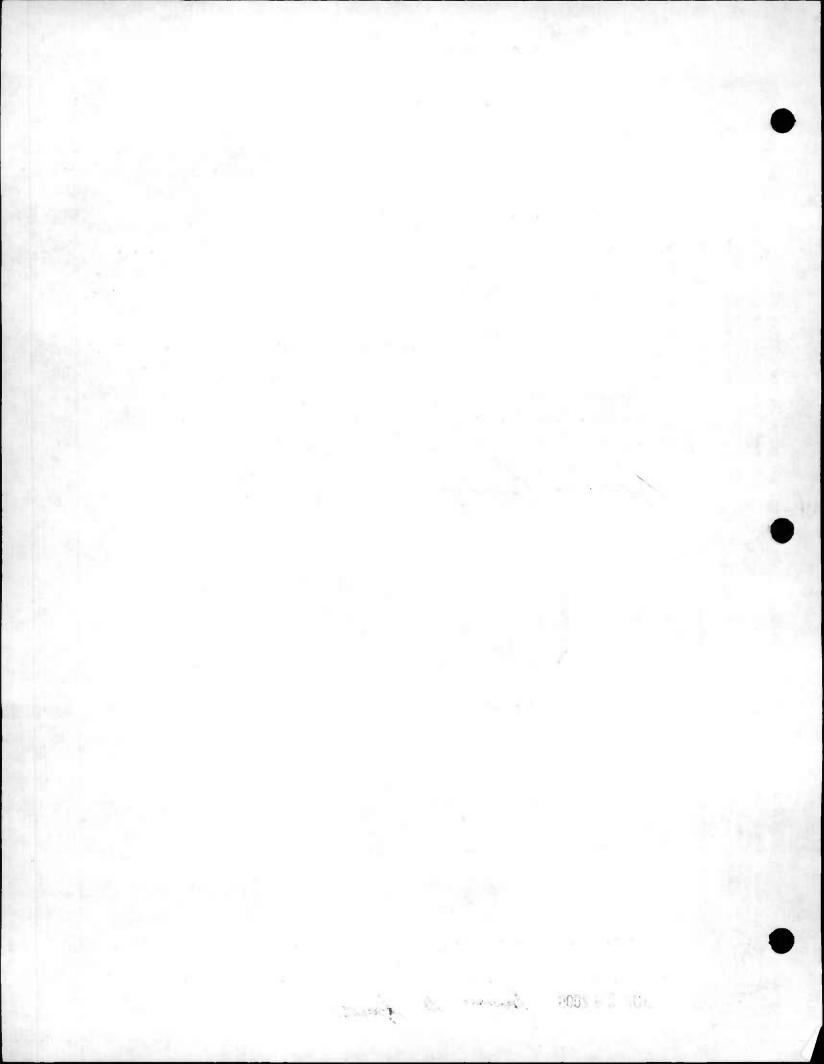
State

Barry N. Rosenbaum M.D.

31. Data filed (Month, Day, Year)
JUN 2 6 2009

2. Registrar's Signature

3720 Farragut Ave. Kensington, MD 20895-2110



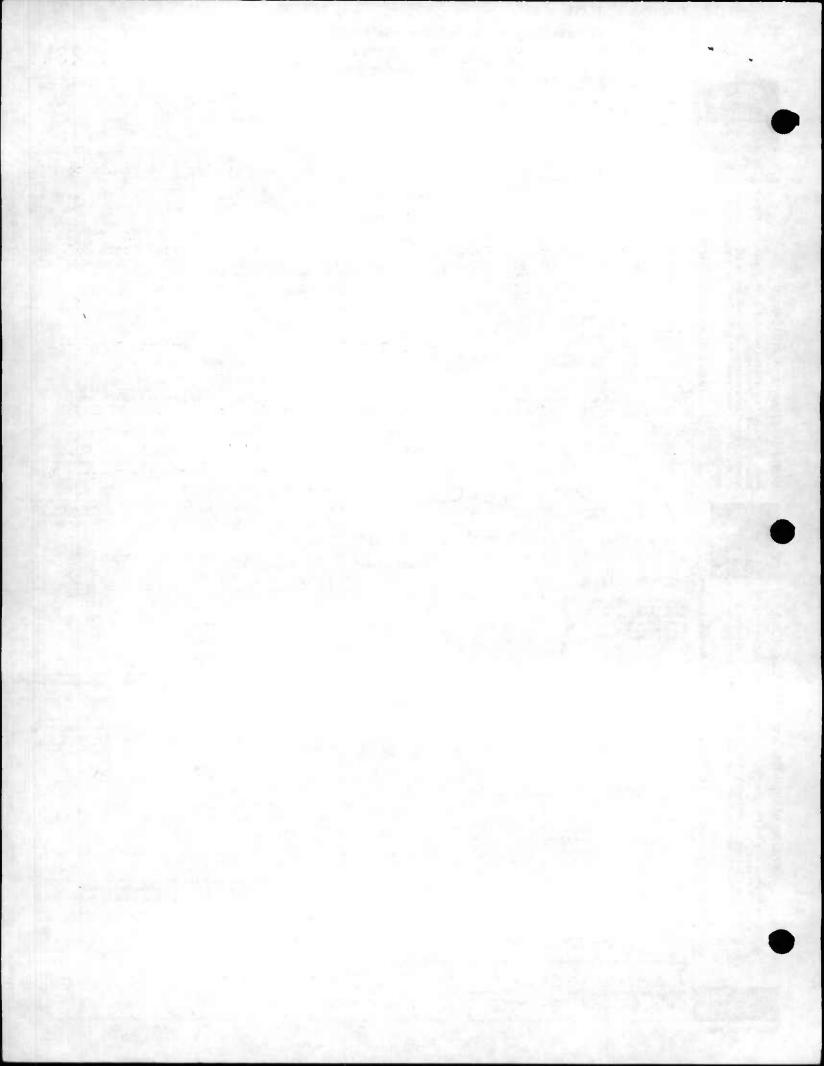
State Registrar

111 Penn Street, Baltimore, Maryland 21201

30. Name end address of person who completed cause of death (Item 23a) (Type, Print) West, mo

32. Registrar's Signature

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State of Maryland / Department of Health and Mental Hygiene 00 22235

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	0	OF	FICE WOR	KER		MANUF	FACTUE	RING
DAVID KAHEMAN	ast)			18. Mother's Na	me (First, Middle,	Maiden Sumen	ne)	
DITATE MUCLIMIA				CARRIE	RISH			
19a. Informant's Neme/Relationshi	lp (Type, Print)	19b. Maili	ng Address (Stre	et end Number or Ri	rel Route Numbe	er, City or Town,	Stete, Zip	Code)
KENTH DITE/TOILS	T OFFICER	551	MATN ST	IOHNSTOL	IN PA 15	5901		
20a. Method of Disposition		. Place of Dispo	sition (Neme of		Date		City or To	wn, Stete
	3 Removal from State				-24-00	TOUNCTO	NLINI D	A
					-24-00	JUMSIC	JWIN, FE	1
Immediate Cause (Finel disease or condition resulting in deeth) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Pert II. Other significant condition	b	o (or as a consec	Quence of):					
					240 14/00		Zah Wa	ere autopsy findings
					perfo	ormed?	eva	ailable prior to impletion of cause
						. /	of	death?
					10'	Yes 2 100	10	Yes 2 No
25. Was case referred to medical axaminer?		/			ath (Check only o	one)	. 13.31	
1 ☐ Yes 2 ☐ No	1 Linpatient 2		IL SEL DOA	→ □ Nuising r	Home 5 ☐ Resid	dence 6 □Oth	ner (Specify	y)
	28a. Dete of Injury (Month, Dey Year,	28b. Time of Injury			28d. Describe	how injury occur	rred	
2 Accident investige 3 Suicide 6 Could no	ot be 28e. Place of Injury - A	t home, farm, at			28f. Location (: City or Tou	Street and Numb wn, State)	ber or Rure	i Route Number,
(Check only 2 Medical E:	xaminer: On the basis of exam	nowledge, deat Inetion and/or In	h occurred at the vestigetion, in my	time, date and place y opinion, deeth occu	e, and due to the urred et the time,	cause(s) and modate end plece,	enner as st	tated. the ceuse(a)
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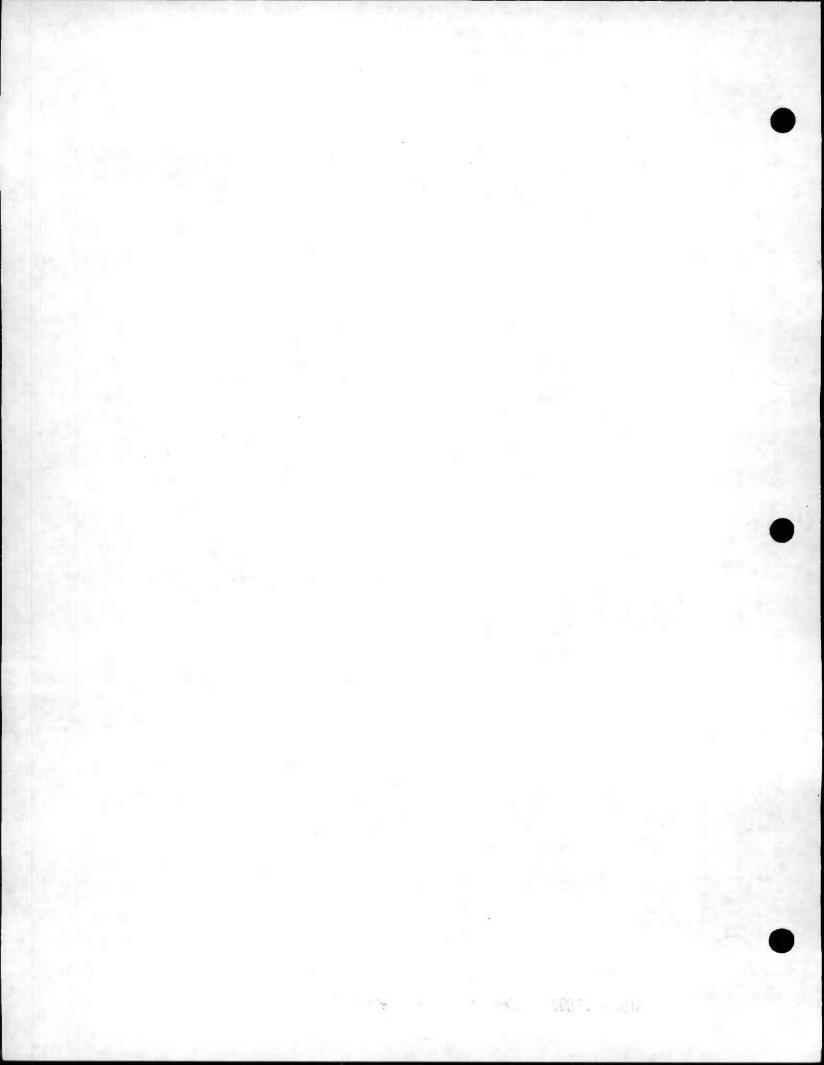
Please Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22236 Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death **Physician** Vivian Grace June 28 2000 3:20 A.M. /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Asbury Methodist Village Nursing Home Montgomery Gaithersburg If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 9. Birthplece (State or Foreign Months | Deys | Hours | Min. | Dec. | 11, 1919 | North Dakota 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1□ M 2 F 80 Yre 213 38 4352 Director Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Int: If them 27 ie marked other than "natural", or thems 23s or 28s-f ehow 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or itema 23a or 28a-f sho other traumatic event, the Heolical Examinal must be notified as 1 Yes 2KMo Director Maryland Montgomery Gaithersburg 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 301 Russell Ave. No.215A 20877 United States Funeral Raca - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Merried 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 Specify: White 1 Yes 200No Specify: þ 3€Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Prince George's Elementary/Secondary (0-12) College (1-4or 5+) 12 Hospital Service Representative 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pemit. Pages 1 and 2 should be f Department of Health and Mental I Important: If tiem 27 is marked oft any injury or other traumatic even Victor Esson Sophie Margaret Hatalie 19a. Interment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Beverly J. Krakat Daughter 15521 Eagle Tavern Lane Centreville VA 20120 20b. Place of Disposition (Name of cemetery, crematory or other place) June 29, Date 2000 20e. Melhod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory Alexandria Virginia 21. Signature of Funeral Service Licenses 22. Name and Address of Fecility
Robert E. Evans Funeral Home, Inc. 16000 Annapolis Rd. Bowie Maryland 20715 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Chronic renal failure Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dependent Diabetes Mellitus uears Physician/Medical Examiner The law requires that the death certificate be executed use as the bunal-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lesf and Box 68760, Due to (or es e consequence of) 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yee 2 dyo 3 Probably 4 Unknown à 24b. Were eutopsy tindings evailable prior fo completion of cause of deeth? 24a. Was an autopsy performed? funeral director, page 2 should Be Completed certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: 25. Wes case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residenca 8 Other (Specify) 1 Yes 2 No To 27. Menner of Death 28d. Describe how Injury occurred Medical Certification: 28c. Injury at Work? 5 Pending investigation 1 Natural 2 Accident after death. Director: Af 1 Yes 2 No the 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 3 Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and placa, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number Ellen mlinhour mD D51015 30. Name and address of person who completed cause of death (Item 23e) (Type, Print) #1045 CheryChase, MD 20815 Ellen finholt mD 5530 Wisconsin Are 32. Registrar's Signature 31. Date filed (Month, Day, Year)

DHMH 16 Rev 6/95

Registrar

JUN 3 0 2000



Please Type or Print in Black indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22237

			Cen	tificate of	Death		Reg. No.	22231		
Physician	1. Decedent's Neme (First, Middle, L		37.30			2. Dete of De		3. Time of Death		
Physician /Medical	Raymond	Hall				June 22	, 2000	4:20 P.		
Examiner	4e Facility Neme (If not institution, g	ive street and number)				Location of Death				
	Spa Creek Genesi:			If Under 1 Year	nnapolis		Anne Ar			
Funeral Director	579-14-0735	Sex 1 M 2 F 7. Age (In yrs 7)	(s. last birthday) 9 Yrs.	Months Days	Hours Mir	November	y, Year), 1920	9. Birthplace (State or Fore Country) Washington,		
p .	Usual Residence of Decedent 10a. State 10b. County	10c C	ity, Town or Loc	eation				10d. Inside City Lim		
taryt ad a	Maryland Anne Ar		apolis					1 ☐ Yes 🔏 ☐		
vith the Ma t or 28a-f s be notified Director	10e. Street and Number	didel Aiii	apoiis	10f. Zip Code			10g. Citizen of Whet Country?			
	35 Milkshake Lan			2140			U.S.A.			
or after at, or its Examine by Fur	11. Marital Status 1 □ Never Merried 2 □ Married XX Widowed 4 □ Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Vas Decedent of I Yes, specify Cub ☐ Yes 2 No		Specity Yes or No rto Rican, etc.)	Black	- American Indian, , White, etc. White		
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un and aldu	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wed)	, many				
Hygiene. Hygiene. Ther then out, the Me	12		Boat	Mechanic			Marina			
Mental H writed oth affic even	17. Father's Name (First, Middle, Las Roland Hall	st)				ame (First, Middle, gianna	Meiden Sumeme Lamb)		
SPEE	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailing	g Address (Street	end Number or F	Rural Route Numbe	er, City or Town, S	Stete, Zip Code)		
27 th	Bonnie Griffin /	Daughter	8204 W	oburn Ab	bey Rd.	Glendale	, MD 207	69		
Pages 1 a tent of He mt: if Item my or othe	20a. Method of Disposition 1 Burial 2 Cremation 3 4 Donation 5 Other (Spec	20b. ☐Removal from State		sition (Neme of letory or other pla n Cemete		Date 26,2000		city or Town, State		
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ing physicie e es the bur Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a consequ	ence of):						
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Within ompi	29b. Signature and title of certifier			29c. Licen	se number		29d. Date signed	(Month, Dey, Year)		
0	1 9 9 80	mue		D	32036		4/2	1/2000		
(6)	30. Name end address of personam	completed cause of death (ite	om 23a) (Type, F	Print) Driv	· Class	er, MI)	21619			
State	31. Dete filed (Month, Dey, Year)	32 Registrar's Sign	nature	1 .						

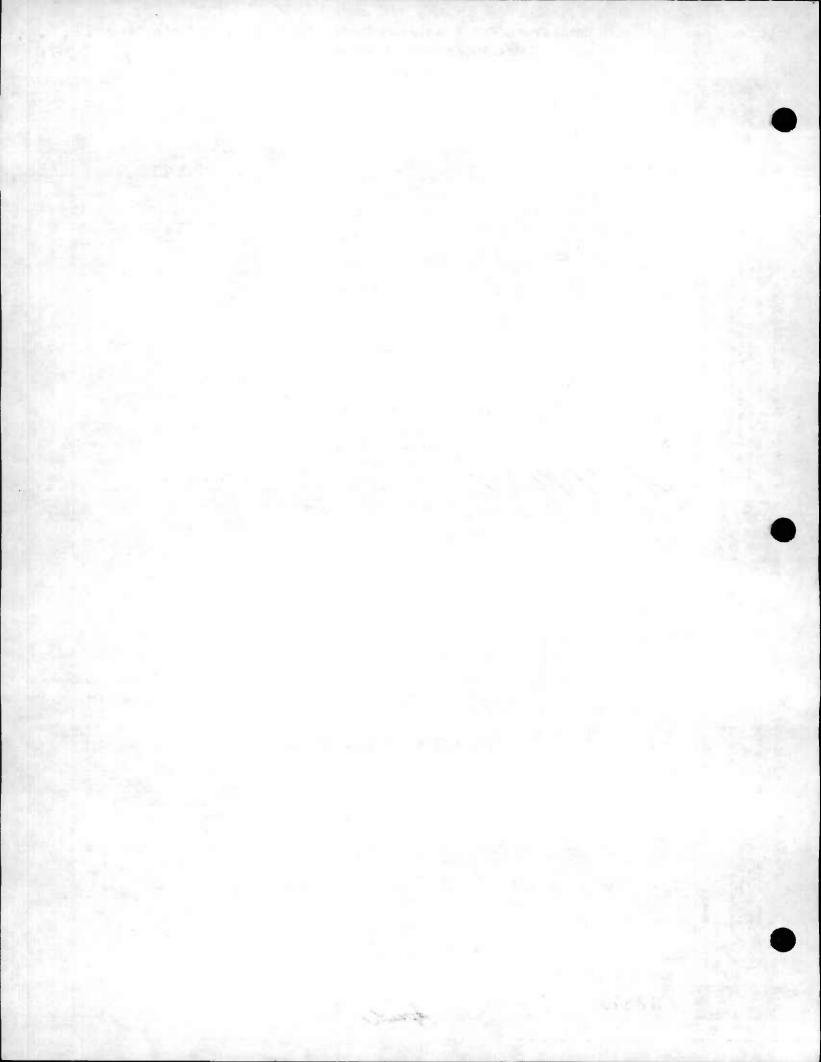
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State of Maryland / Department of Health and Mental Hygiene 00 22238

			Ce	rtificate of	Death		Reg. No.	, ,	2200		
Discontation	1. Decedent's Name (First, Middle, I	ast)				2. Dete of De Month		Yeer	3. Tima of Death		
Physician /Medical	John	Hlavay	-49241				22,2000	1001	12:55 A		
Examiner	4e Facility Name (If not institution, g	ive street and number)			4b. City, Town, or			f Death			
	Southern Marylar	nd Hospital			Clinton		Prince	e Geor	rges		
Funeral	Social Security Number 6		rs. last birthday)	If Under 1 Yaar Months Deys		8. Dete of Bir (Month, De	th v. Year)	9. Birthpled	e (Stete or Forei		
Director	185-12-1738 Usual Residence of Decedent	¹ X ^M ^{2□} F 77	Yrs.			Dec.1		Ohio			
ehow ed at	10a. Stete 10b. County		City, Town or Lo				10d. Inside City Lin				
Ma To	Maryland Prince	Georges	Capita	1 Height	S		1 XYes				
affer death with the Maryle or items 23s or 28s-1 shot must be notified at the Tuneral Director	10e. Street and Number 908 Mentor Avenu	ie		10f. Zip Code 2074	3		10g. Citizen of What Country? United States				
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ed within 72 hours after death with the Maryland ygiene. We than "natural", or items 23a or 2844 show it, the Medical Examiner must be notified at Completed by Funeral Director	15. Decedent's (Specify only highest g		/Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wor	rking	16b. Kind of Bus	iness/Indus	stry		
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marked off marked off marke ever	Andrew Hlavay	ii)			Capatin	Maiden Surneme	,				
S D E E	19e. Informant's Neme/Relationship	(Type, Print)	19b. Meili	ng Address (Stree	t and Number or Au	ural Route Numb	er, City or Town, S	itete, Zip C	ode)		
4 4 20	Peter J. Hlavay	(Brother)	192	1 Kirkby	Dr. Sout	h Park,	Pa. 151	L29			
00 = 1	20a. Method of Disposition	Dete 6-27-00	Dete 20c. Location - City or Town, State -27-00 Suitland, Maryland								
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/Medical Examiner	Immediete Cause (Finel disease or condition resulting in deeth)		Cellu Periol	quenca of):	Vascula	ar DH	sease				
law requires that the death certificate be executed as been signed by the attending physician and a 2 should be detached for use as the burial-transit npleted by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury c.										
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dale of Death 3. Time of Death Month **Physician** 23, 2000 Mary O'Brien Higgins June 5:00AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Bradford Oaks Nursing Home Clinton Prince George If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplaca (Stata or Foraign Country) **Funeral** 1□M 2□F Days Yrs 107-10-7119 Director July 31, 1917 New York Usual Rasidance of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show 1 ☐ Yes 2 ☐ No Director Maryland Prince George Upper Marlboro 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 234 6824 Carroll Way 20772 United States 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Yaar or Datas: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Haalth and Mental Hygiena. Important: if Nem 27 is marked other than "natural" any Injury or other traumatic averages. 1 Never Merried 2 Married 1 Yes 25 No Specify: Specify: White 3 Widowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) New York Elementary/Secondary (0-12) College (1-4or 5+) 12 Secretary State Government 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Patrick O'Brien Emma Call 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Steta, Zip Code) 20b. Place of Disposition (Name of cematery, crematory or other place)

6824 Carroll Way Upper Marlboro, Md. 20772

Dete 20c. Location - City or Town, State Patricia Higgins/ Daughter 20a. Method of Disposition 1 Purial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Holy Name Church Cemetery 6/29 AuSable, N.Y. 22. Name and Address of Fecility 21. Signature of Funeral Sc Lee Funeral Home, INC. 6633 Old Alexander Ferry Rd. Clinton, Md. 20735 ack 1 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner cartificata be axecuted Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury Ihal initiated events resulting in deeth) Last Due to (or as a consequence of) 68760 Dua to (or as a consequence of) Box P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 thinknown 1 Yes 2 No RIENGION Records, Completed by E HEART PAILURE 24b. Were autopsy tindings available prior to 24e. Was an autopsy complation of causa of death? 1 Yes 200 1 ☐ Yes 2 ☐ No Vital or Attending Physicien: Be 25. Was case refarred to medical 26. Place of Death (Check only one) Other: Mursing Home 5 Residence 6 Other (Specify) 1 Yes 2 A 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To Division of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how Injury occurred 5 Pending investigation To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A complataly filled in by tha fu death. 1 Yas 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as stated. 29a. Certifiar (Check only one) 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated. 29b. Signature end little of certifier 29c. License number 10 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) LASIDORFMD 20602 6B PRISTANSO ASHVINKUMBE 31. Data filed (Month, Day, Ye JUN 2 7 2000 32. Registrar's Signature State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 0845Am VERONICA HICKERSON 2000 JUNE /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore St. Agnes Health Care If Under 24 Hrs. Hours Min. 5. Social Security Number If Under 1 Yeer Birthpiace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months 1 M 2 K) F 577-72-9868 Director 3,1954 Washington, D.C Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Maryland Prince George's 1 Yes 2 □ No Bowie Directo 10e. Street and Number 10f. Zip Code 10o. Citizen of What Country? Harrie 23a or 8706 Maple Street 20715 U.S.A. Funeral 14. Race - American Indian, Black, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: tXXNever Married 2 ☐ Married natural, or Maryland 21215-0020 Black 1 ☐ Yes 2 2 No Specify: Specify: ğ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 12th College (1-4or 5+) Data Engtry Clerk Private 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: If Nem 27 is marked of Charles Hickerson Gardenia Cooper 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 19a. Informant's Neme/Relationship (Type, Print) Tarita Hickerson/Daughter 5601 Parker House Terrace, #308, Hyattsville, MD Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 06/27 20c. Location - City or Town, State 20a. Mathod of Disposition 1 ☐ Burial 2 【X Cremetion 3 ☐ Removal from State Chesapeake Crematory Beltsville, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 2000 21. Signature of Funeral Service Licenses J. B. JENKINS FUNERAL HOME leve 7474 Landover Road, Landover, Maryland 20785 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or hear terms. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Finat disease or condition resulting In death) ard 10 Examiner Examine onar burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to for as a of and physician 68760 Physician/Medical Due to (or es e consequence of) Box 950 Part ff. Other eignificant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 4 2 1 Yes 2 No 3 Probably 4 Dunknown مَ pertension monar by Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 Pyes 2 No certificate 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: edical Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death s after death. I Director: After th 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rurel Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Hospital or To the Hospital within 24 hours a To the Funeral Completely filled 112 Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and attack of the 29c. License number June da 2000 M.D. AGNES HEALTHCARE 30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print) hristian BALTIMORE, MO tansen 900 1. NY CATON AVE 32 Registrar's Signeture 31. Dete filed (Month, Day, Year) 2/229 JUN 2 6 2000 Registrar

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Funeral Director	MD		George's	Dis		eight	5			1½ Yes 2 □ N
	10e. Street and 2107	Number Harwood Ct				ip Code 0747		C. W.	10g. Citizen of V	What Country? JSA
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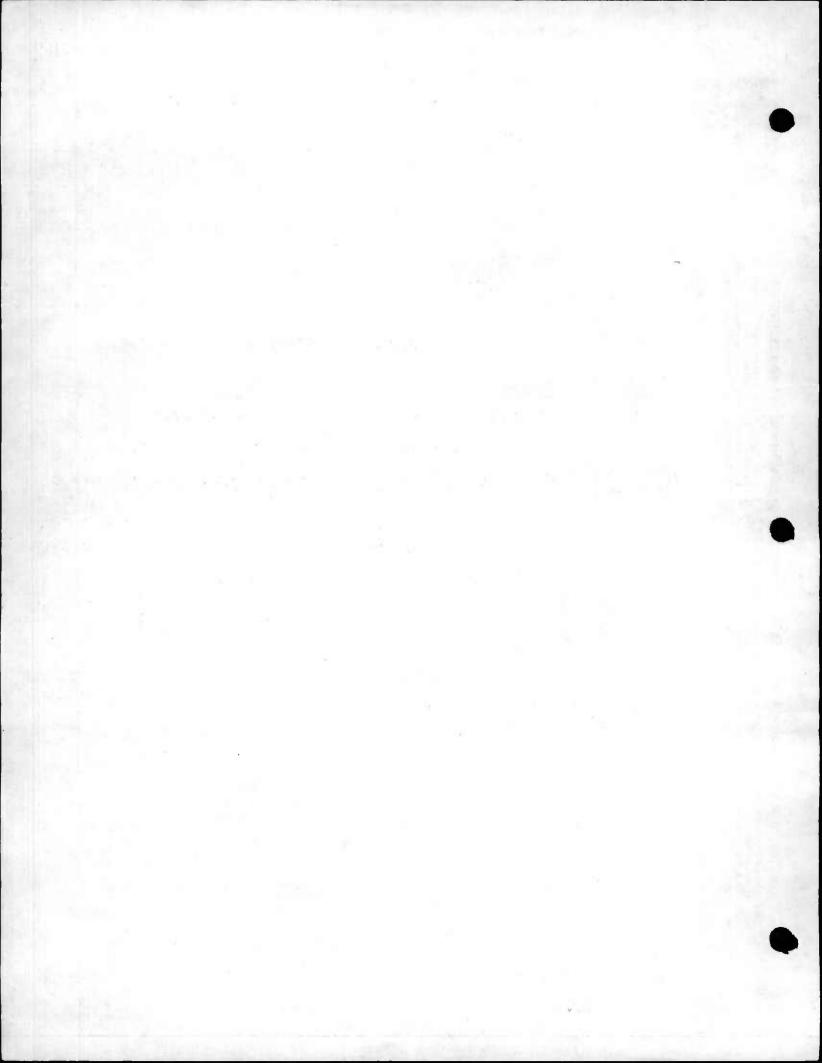
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Deeth Month 06 **Physician** 2:55 p.m. 2000 LUDWIG HEDDERICH /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Caroline Nursing Home Denton Caroline If Under 1 Year If Under 24 Hrs. 5. Social Security Number Birthplece (State or Foreign Country) 6 Sax 8. Dete of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1)() M 2□ F 90 Yrs. 216-07-7842 Director NOV. 13,1909 MD Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits 1X Yes 2 No DENTON Director MD CAROLINE 288-1 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò or items 23a caminer must be 21629 520 KERR AVENUE USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ঐ No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Stetus Bleck, White, etc. filed within 72 hours after 1 □ Never Merried 2 □ Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: WHITE à 3 ☐ Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) LOCOMOTIVE ENGINEER RAILROAD 3 permit. Pages 1 and 2 should be life Department of Health and Mental Hy Important: If Item 27 is marked oths any injury or other traumatic event 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surname) Be KATHARINE SCHMIDT 2 PHILLIP HEDDERICH 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1006 HILLENDALE ROAD, GRAY, TN 37615 DR. RONALD L. HEDDERICH/SON 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location · City or Town, Stete 1 ☐ Buriel 2 ☐ Cremation 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN MEMORIAL PARK 7-01-00 EASTON, MD 21. Signature of Funerel Service Licensed 22. Name end Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, PA aim 200 S. HARRISON ST. EASTON, MD 21601 Approximete Intervel Between Onset end Deet 23e. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Finat disease or condition resulting in deeth) /Medical Examiner Due to (or as a consequence of) Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of) 68760 Due to (or es e consequence of) Box P.O. 1 Pert II. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings evelleble prior to 24e. Wes en eutopsy performed? completion of cause of deeth? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificata Division of Vitai Hospital or Attending Physician: 124 hours after death.
 Funeral Director: After this certificalietely filled in by the funeral director; j 25. Wes case referred to medical exeminer? 80 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Menner of Deeth 1 Polyeturat 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Sulcide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 29e. Certifier Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, and due to the cause(s) end manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29b. Signature and title of certifier 29c. License numbe 29d. Dete signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sames

State Registrar

31. Dete filed (Month, Day, Year)

32. Registrar's, Signature

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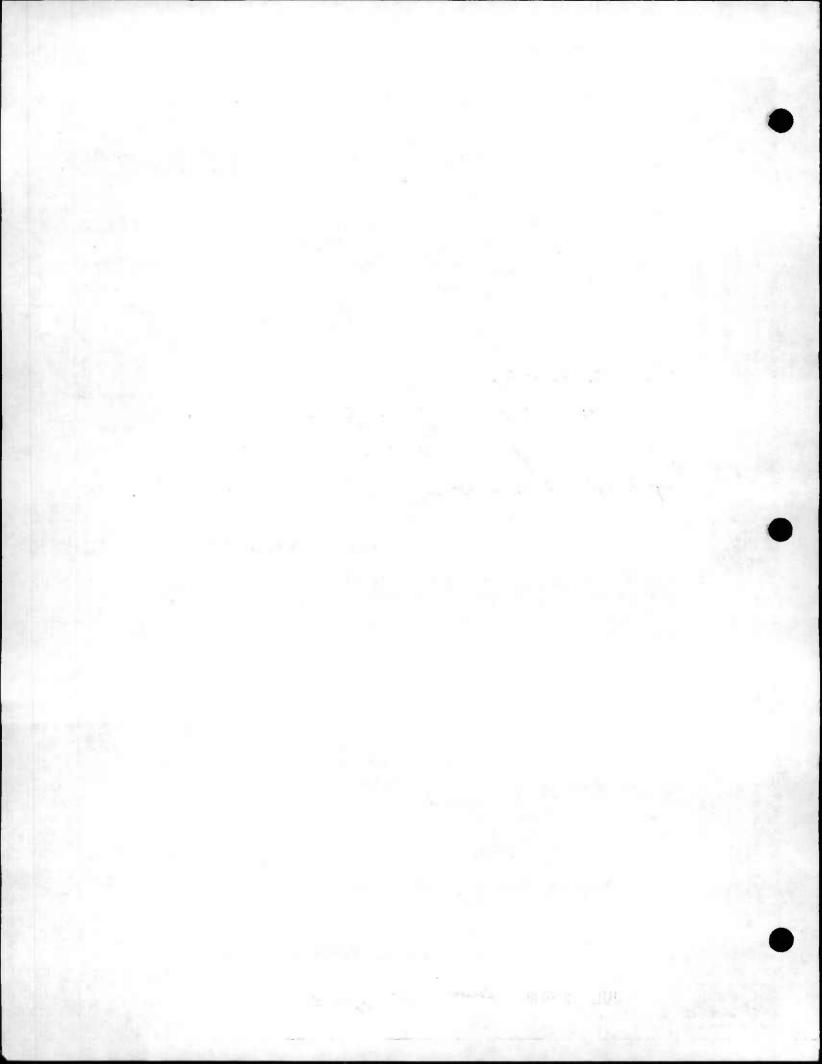
State of Maryland / Department of Health and Mental Hygiene 22243 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** HARTLEY CLARENCE E. Jr. 2000 June 30 3:06 AM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Baltimore City BALTI MORE
If Under 24 Hrs. 8. Dete of B ADMINISTRATION HOSPITAL 5. Social Security Number 7. Age (In yrs. lest birthdey) 74 Yrs. 8. Dete of Birth (Month, Day, Feb. 2, Birthplece (State or Foreign Country) **Funeral** 1 M 2 □ F Months Days 230-24-0198 D.C. Feb. Director Usual Residence of Decedent 10a, Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Carroll Sykesville 1 Yes 2 No Funeral Director 10e. Street end Number 10f. Zip Code 10g. Citizen of What Country? b 23a 4309 Morris Dr. 21784 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If them 27 is married other any injury or other treatment other any injury or other treatment. Was Decedent of Hispanic Origin? (Specify Yes or Noff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien. 11. Meritel Stetus 12. Wes Decedent Ever in U,S. Armed Forces? Bleck, White, etc. 1 X Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 Divorced Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Carpenter Homes 12 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Clarence E. Hartley Sr. Marjorie Cave 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 4309 Morris Dr. Sykesville, Md. 21784 Wileen M. Hartley (Wife) 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State
4 Donellon 5 Other (Specify) Smithsburg Crematory 2000 Smithsburg. Md. Signature of Funerel Service Licens 22. Neme end Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 Fant. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Immediete Cause (Finel diseese or condition resulting in deeth) /Medical INTRACEREBRAL HEMORRHAGE Examiner Physician/Medical Examiner HYPERTENSION 40 YEARS The law requires that the death certificate be executed attending physician and I for use as the burial-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in deeth) Lest Due to (or es e consequença of): Records, P.O. Box 68760. Due to (or es e consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? is certificata has been signed by director, page 2 should be detect 3 Probably 4 Unknown 1 Yes 2 No Be Completed by 24b. Were autopsy findings evailable prior to completion of cause of deeth? 24a. Wes an autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No After this certificate of Vital To the Hospital or Attending Physician: within 24 hours after death.

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2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date end place, end due to the cause(s) and menner stated. 29e. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signeture and title of certifier 29c. License number MO June 30, 2000 13109 4909 LOCKARD 30. Neme and address of person who completed cause of deeth (Item 23a) (Type, Print) MILLS, 31. Dete filed (Month Dey, Year) 3 2000 32. Registrar's Signature

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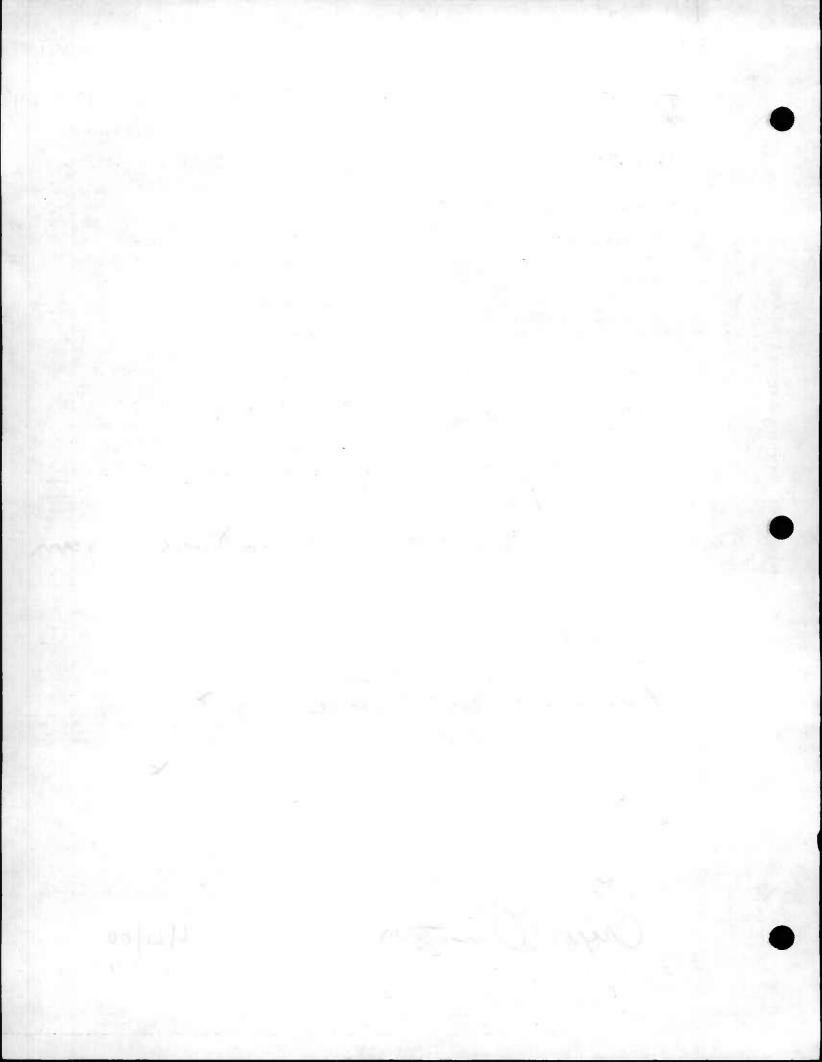
State Registrar



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ylanc buid be fi Mental H Mental H arked out artic aver		oodeau	Veronica	Fitzgera	ald		
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Baltimore, Maryland 212: permit. Pagas 1 and 2 should be filed within Department of Health and Mental Hygiana. Important: if Item 27 is merked other than any injury or other traumatic avent, the Mones. To Be Compl	20e. Method of Disposition 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donetton 5 Other (Specify)	20b. Piece of Disposition (Name cametery, crematory or othe Smithsburg Cremat	ory, June 30, 2000	20c. Location - City o	g, Maryland		
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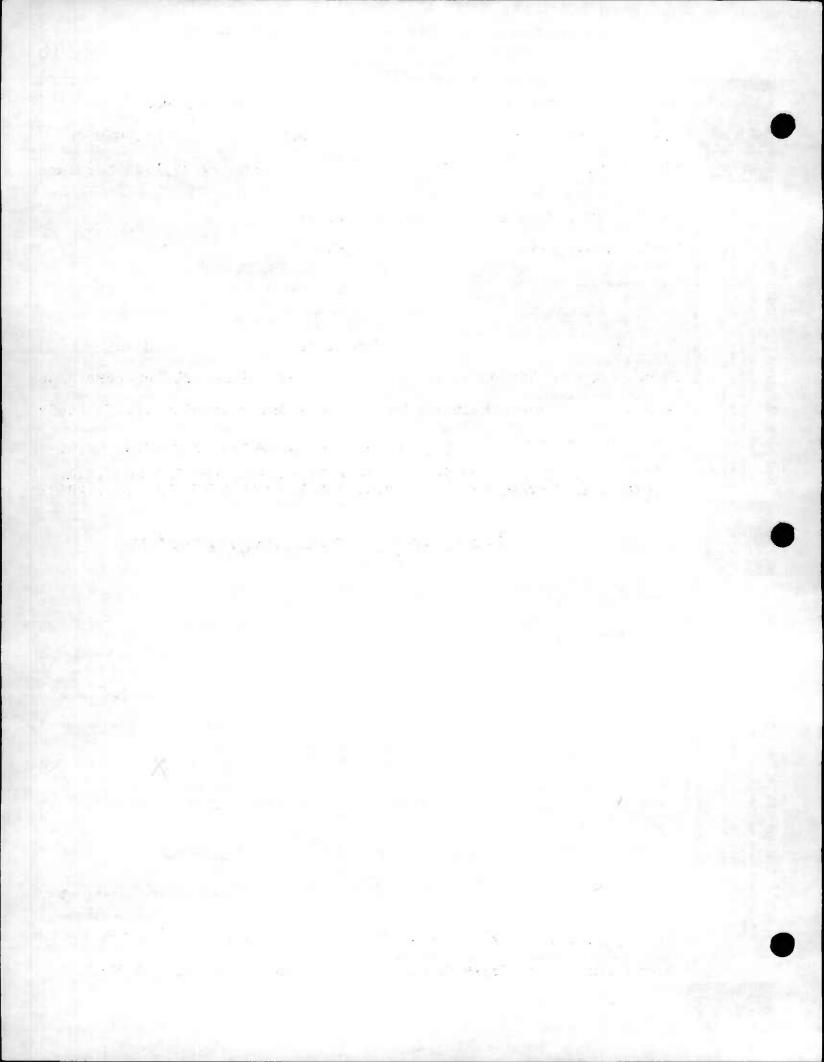
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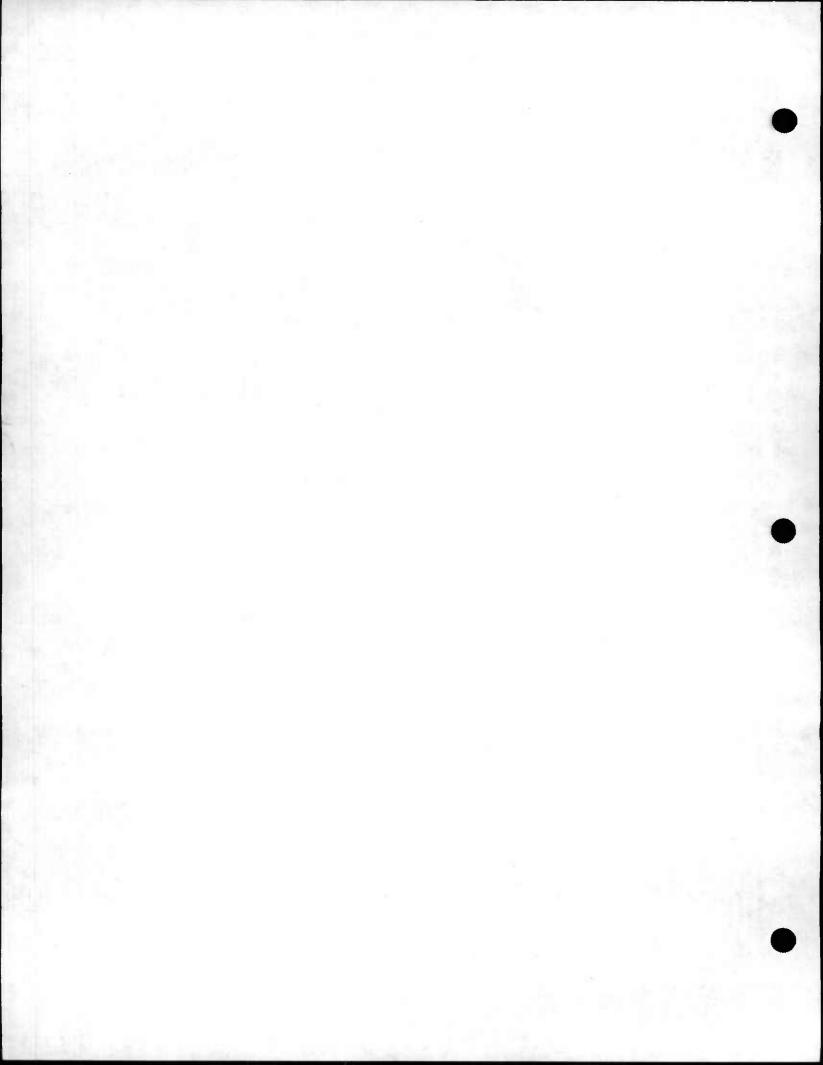
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/Medical	Nellie Ann Hick			dh Ciba Taum and	July 2,	2000			
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or 28	10e. Street end Number		10f. Zip Co		10	10g. Citizan of What Country?			
eth w	39498 Thomas Dr		206			USA			
21215-0020 within 72 hours after deeth with the Maryland jiene. If then "natural", or items 23s or 28s-1 show the Marical Evaninet must be notified at completed by Funeral Director	11. Maritel Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Detes:	13. Wes Deceden If Yas, specify 1 ☐ Yes 2	t of Hispanic Origin? (S Cuban, Mexican, Puerl No Specify:	pecity Yas or No- o Rican, etc.)	14. Race - American Indian, Black, White, etc. Specify: White			
5-0 72 ho	15. Decedent's Edu (Specify only highest gred	(cation	16a. Decedent's Usuel C	fone during most of wo		6b. Kind of Busi	ness/Industry		
Iryland 21215-002 should be filed within 72 hours e and Mentel hygiene. marked other than "natural", o imatic avant, the Marical Exar To Be Completed by	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use I	etired)					
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2000	Herbert W. Hick	mann/Husban	1 39498 Th	omas Dr.	Mechani	sville	,MD 20659		
other tr	20a. Method of Disposition	20b. Ple	ce of Disposition (Neme	of			ty or Town, State		
Baltimore, semit. Pegas 1 a Separtment of Hee mportant: if Nem iny Injury or othe	1 Buriel 2 Cremetion 3				77/8/00	Pomfre	t,Maryland		
Baltimo pamit. Pega Department of important: if any injury or	21. Signature of Funeral Service Licens			TELD-ECHO					
Depa Impo	Abund C. G	hal 19094.					MD. 20622		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o	lications that caused the death.					Approximate intervel Between		
Medical Examiner in end included Examiner Examiner Examiner	Immediate Ceuse (Finel diseese or condition resulting in death)	b	m V 0 50 as a cossequenca of):	rcom	a, meta	static			
68760 filicata be g physicia as the bur	Ceuse (Disease or injury that initiated events resulting in deeth) Lest Due to (or es e consequenca of):								
Box bath cert for use		d							
dS, P.O. BO) ires that the death ce signed by the ettend d be datached for us. d by Physician/	Part II. Other significant conditions co	ntributing to death but not resul	ting in the underlying caus	se given in Part I.	23b. Dld tot	23b. Did tobacco use contribute to the cause of death			
P datac					1 □ Ye	8 2□ No 3	Probably 4 Unknow		
II RECORDS, The law requires the law seen signe page 2 should be d		eutopsy ed?	24b. Were autopsy findings aveileble prior to completion of cause of death?						
The lay sta has page 2					1□ Ye	s 2XINo	1 ☐ Yes 2 No		
= - 50 0	25. Wes case referred to medical			26 Place of De	ath (Chack only one	/\	18165 22110		
Of Vita Physician: this certific ral director,	examiner?	Hospital: 1 ☐ Inpatient 2 ☐ E	R/Outpatient 3 DOA	Other:	Home 5 Reside		(Specify)		
Physical dispersion of Tr. To	27. Manner of Deeth	1	28b. Time of 28c	injury at Work?	28d. Describe ho				
Division o To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completaly filled in by the funeral Medical Certification;	1 Naturel 5 Pending 2 Accident Investigation 3 Sulcide 6 Could not be		М	1 ☐ Yes 2 ☐ No					
or Att after of Direct in by	4 Homicide determined	28e. Plece of Injury - At hor building, etc. (Specify)	ne, ferm, street, factory, c	ffice	City or Town	eet and Number , Stete)	or Rurel Route Number,		
Pital Purs a Purs a Filled	29a. Certifier Certifying Phy	eloien: To the heat of my local	ledge death conversed at	the time date and also	a and due to the co	uso(s) and mos	nor as stated		
ne Hospi ne Funer pletaly fil		sician: To the best of my know iner: On the basis of examinetic and manner stated.	on end/or investigation, in	my opinion, death occ	urred et the time, da	ite and place, an	d due to the ceuse(s)		
To the Hospital within 24 hours To the Funeral I completely filled Medical Co	29b. Signeture end title of cartifier	())	29c. L	icensa number	29	d. Date signed	(Month, Dey, Year)		
- 5 - 0	Alama-	Harring	mp p	00 529	119	7/3/	00		
	30. Name end address of person who c	ompleted cause of death (Item)				11			
	James Herring,		ee Notch	Rd. Charl	otte Ha	11,MD	20622		
State	31. Deta filed (Month, Day, Yeer)	32. Ragistrar's Signet	ira 4 /						



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State of Maryland / Department of Health and Mental Hygiene 00 2224 6

				117	Certific	ate of	Death		Reg. No.	0 22240
		1. Decedent's Nama (First, Middle, Las	1)		1314			2. Dete of De Month	eth	3. Time of Death
	ysician Iedical	Agnes Dale Hix	kson					July	2 20	
	aminer	4a Facility Name (If not institution, give					4b. City, Town, or	Location of Death	4c. County of	of Death
		Charles County		g Reh			La P			rles
Fund Direct		5. Social Security Number 6. Se 440-03-1972 Usual Residance of Decedent	7. Age	(In yrs. last		ths Deys			, 1917	Birthplace (State or Foreign Country) Oklahoma
Bund W.		10a. State 10b. County	P 1400	10c. City, To	own or Location					10d. Inside City Limits
th with the Maryla 23s or 25s-f show	to to	MD Charl	AC	Col	bb Isl	and				X□Yes 2□No
5 K	be notified Director	10e. Street and Number				Zip Code			10g. Citizen of W	hat Country?
2 m	al E	12504 Neale Sc	ound Driv	re			20625		USA	
hours after dea hursi', or items	Examiner must by Funeral	11. Merital Status 1 □ Never Married	12. Was Decedent E Armed Forces? 1 Yes 2 N If Yes, Give Yeer or Detas:			ecedent of specify Cul	Hispanic Origin? (s ban, Mexican, Pual Specify:	Specify Yes or No rto Rican, etc.)	- American Indian, K, White, etc. White	
72 ho	ted ted	15. Decedent's Edu		10	6a. Decedent's I	Jsual Occu	pation	etine	16b. Kind of Bus	sinass/Industry
within 7	t, the Medical	(Specify only highest grad Elamantary/Secondary (0-12)	College (1-4or 5-	+)	life. DO NO	T use retin	e during most of wo	orking		
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and State	Be (17. Father's Name (First, Middle, Last)						me (First, Middle,)
yla Man	To all	Gilbert R. Dale						a Harri		
, Maryland 21215-0020 and 2 should be filed within 72 hours at eaith and Mental Hygiene. n 27 is marked other than "neturel", or	er traum	J. Howard Hixs		Son :	P.O. B	ox 1	93 Vall	ey Lee,	MD 2069	92-0193
Baltimore,	ury or oth	20a. Mathod of Disposition 1 Burial 2 □ Cremation 3 □ 1 4 □ Donation 5 □ Other (Specify,		ceme	of Disposition etery, crematory t Linc	or other pla		y7/6/00		City or Town, Stete wood , Marylai
Balt Depart	any in	21. Signature of Funerel Service Licens	MO MO	0945	22. Nam P.	EHAR O. B	T-ECHOL OX 567	S FUNER LA PLAT	AL HOMI	E,P.A. 20646
Physic /Medi Exami	ner	immediate Cause (Final disease or condition rasulting in death)	a		e Hear		ilure-E	nd Stag	е	Onset and Daath
Records, P.O. Box 68760, The law requires that the death certificate be executed the has been signed by the attending physician and	S 2	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest	c		a consequence					
Box eath cert	for us									
P.O.	ached hysi	Part II. Other significant conditions co	ntributing to death bu	t not resultin	g in the underlyi	ng cause g	ivan in Part I.	d tobacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
of Vital Records, Physician: The law requires that this certificete has been signed to	2 should pleted					24a. Was	24b. Were eutopsy findings available prior to completion of causa of death?			
ت الله الله الله الله الله الله الله الل	Com							10	Yes XXNo	1 ☐ Yes 2 ☐ No
Vital	Be (25. Was case referred to medical axaminar?						eath (Check only		
Of Vita Physician: this certific	§ 6	1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie		Outpatient 3		ther: XX Nursing			
Affe	lon:	27. Manner of Death A Pantural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	Year) 28	b. Time of Injury M	28c. Inj W 1[ury at ork? ☐ Yes 2 ☐ No	28d. Dascribe	how injury occurr	ad
5 5 to	led in by the funera Certification:	3 Suicide 6 Could not be 4 Homicida determined	28a. Place of Inju building, etc		, farm, straat, fa	ctory, office	8	28f. Location (City or To		ar or Rural Route Number,
e Hospital n 24 hours e Funeral	pletely fill edical	29a, Cartifiar XX Certifying Phy (Check only one) 2 Medical Exami	reiclan: To the best of lner: On the basis of and mannar sta	examination	dge, death occur end/or investiga	rred at tha ition, in my	tima, data and place opinion, death occ	e, and dua to tha curred at the time,	cause(s) and ma data and place, a	nner as stated. and dua to the cause(s)
To the within 2	N Com	29b. Signature end title of certifier				29c. Licer	nse number		29d. Date signed	i (Month, Day, Year)
		Krylen	M-Ma	elt	~	D28	8352		July 3	3, 2000
		30. Name end address of person who of Krishan Mathur				13 1	La Dlate	a MD	20646	
	State	31. Data filed (Month, Day, Year)	32. Registra	r's Signatura	4	Los	M.		20040	



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22267 Amended # 4, P.G. GC, 7/5/00 Certificate of Death 1. Decedent'a Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Yaar Physician June Raymond Leroy Johnson 2201 2000 /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City. Town, or Location of Death 4c_County of Death Examiner Lyn ham Hosfita Doctors Community VINCE H Under 24 Hrs. 8. Date of Birth (Month, Day, Year)
July 22, 1940 5. Social Security Number 311 If Under 1 Year Birthplace (State or Foraign Country) 7. Aga (In yrs. last birthday) **Funeral** Days 1₩ 2□ F 213-38-3803 Yrs 59 Director Wash., D.C. Usual Residence of Decedent 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1 N Yas 2 No Director Maryland Prince George's 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13205 - 9th Street 20715 United States Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ② No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispenic Orlgin? (Specify Yas or No tl Yas, specify Cuben, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, Whita, atc. id be filed within 72 hours after de ental Hyglene. ked other than "natural", or Nem ic avant, the Hedical Examination 1 Never Married 2 Married 21215-0020 1 ☐ Yas 2 ☒ No Specify: Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupetion (Giva kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) 12th College (1-4or 5+) Driver Private Baitimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any Injury or other traumatic avant, page. 17. Father's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumama) Raymond Johnson Elizabeth Fletcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Katie G. Johnson - Spouse 7924 Glenarden Parkway, Lanham, MD 20706 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1X Burial 2 ☐ Cremation 3 ☐ Removal from Stata 7/3/2000 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Cemetery Brentwood, MD ture of Funeral Service Licenses 22. Nama and Addrass of Facility Stewart Funeral Home 4001 Benning Rd., N.E. Wash., D.C. 20019 Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Causa (Final disease or condition rasulting in death) /Medical Arrest secondary to precumonia Examiner Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): 68760. Physician/Medical Dua to (or as a consequence of): Records, P.O. Box Part fl. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yea 2 No 3 Probably 4 Unknown 2 24b. Ware autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed 20 No 1 ☐ Yas 2 ☐ No Division of Vital Attending Physician: After this certific funeral director. 25. Was case refarred to medical 8 26. Place of Death (Check only ona) axaminer? 1☑ Yas 2☐ No Other: 4 Nursing Home 5 Residance 6 Other (Specify) 1 Inpetient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred VICTIM front seal pass enger struck by Another 27. Manner of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1708 1 Yas 2 No 24 hours after death. invastigation MAY 29 2000 2 Accident 6 ☐ Could not be 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28a. Place of Injury - At homa, farm, streat, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide STREET ŏ Route 3 at Conway Road, MARSHAM Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

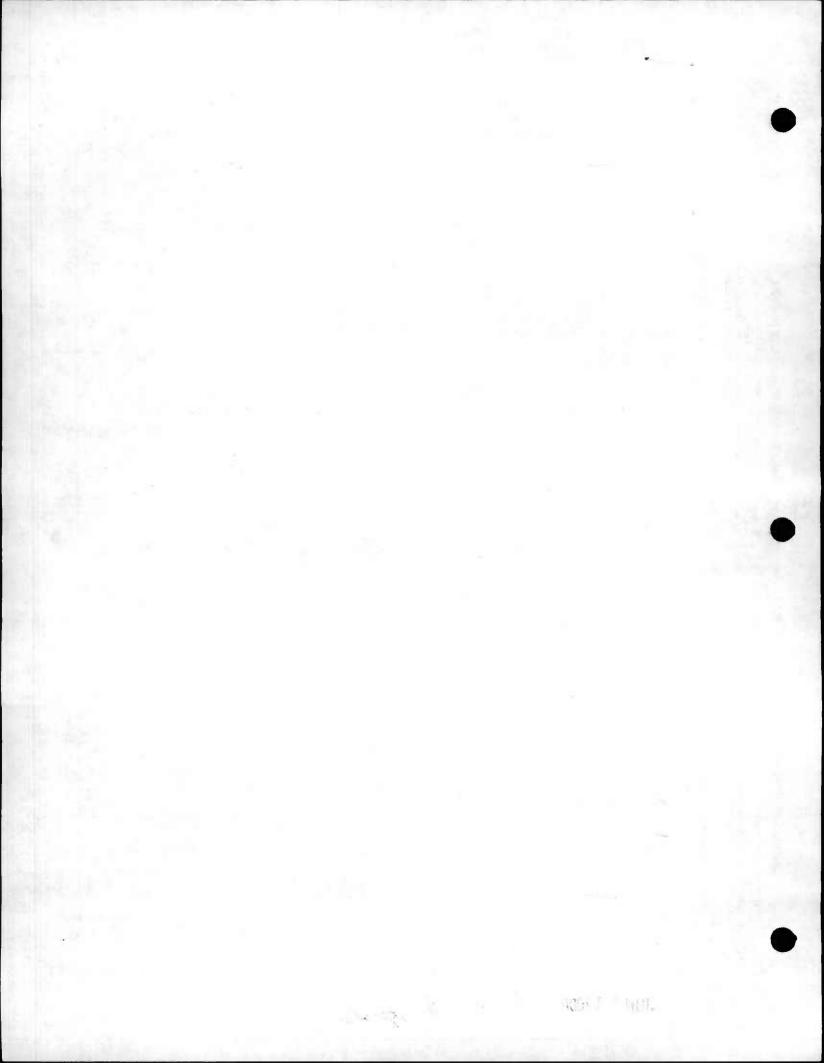
2 Medical Examiner: On the best of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier To the Hosp within 24 ho To the Fune completely fi (Check only one) 29b. Signature and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 110055927 Do

Registrar

30. Name and addrass of person was completed cause of death (Item 23a) (Type, Print)
SALVAGO SUBTER 500 Hospital 31. Data filed (Month, Day, Year) JUN 3 0 2000

32/Registrar's Signatura

Cheverly, Mmyland 20785



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22248 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death June 25, 2000 **Physician** Shirley Ann Jones 8:50 P.M. /Medical 4c. County of Death 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince Georges Regency Nursing Center Forestville If Under 1 Yaar 8. Data of Birth (Month, Day, Year) 5. Social Security Number 7. Aga (In vrs. last birthday) 9. Birthplaca (State or Foreign **Funeral** Months Days Hours 1□M 2日F 57 Director 220-38-2950 10-22-1942 Washington, D.C Usual Rasidance of Decedant deeth with the Maryland 10a. State 10b. County 10c City Town or Location 10d. Insida City Limits ahow the Medical Examiner must be notified at Nayes 2□No Directo 288-1 Maryland Prince George's Forestville 10e. Street and Number 10f. Zip Coda 10g. Citizan of What Country? 6 Nerns 23a 2414 Boones Lane 20747 U.S.A. Funeral 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11 Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health end Mental Hygiene. Important: If I fem 27 ia marked other than "natural". or inportants of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control 1 Nevar Married 2 Married ☐Yas 2☑No f Yas, Giva 1 Yes yev No Specify: Specify: White Completed by 3€Widowed 4 Divorced Yaar or Datas: 16a. Decedant's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedant's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elemantary/Secondary (0-12) Collega (1-4or 5+) 12 Microfiche Clerk Retail 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Surname) Be James Moore Margaret Folk 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leonard Andrew Jones / Son 2414 Boones Lane Forestville, Maryland 20747 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, State Data 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 6-29-00 Brentwood Fort Lincoln Crematory 22. Nama and Addrass of Facility Fort Lincoln Funeral Home of Fungas Service Licensee 141015 3401 Bladensburg Road Brentwood, Maryland 20722 Inter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrast, has failure. List only one cause on each line. Approximata Interval Between Onsat and Death **Physician** Immediata Causa (Final disaasa or condition resulting In death) /Medical a Metastatic Ovarian Cancer Examine Dua to (or as a consequence of): Examiner The law requires that the death certificate be asscuted attending physicien and for use as the buriel-transit Sequentially list conditions, if any, laading to immadiata cause. Enter Undarlying Cause (Disease or Injury that Initiated events rasulting In death) Last Dua to (or as a consequence of): Physician/Medical Dua to (or as a consequanca of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? signed by t 1 ☐ Yee 2 No 3 ☐ Probably 4 ☐ Unknown by 24b. Wara eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate has 1 ☐ Yas 2 ☐ No 1 ☐ Yas 2 X No funeral director. Be 25. Was case refarred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: XXX Nursing Homa 5 ☐ Residence 8 ☐ Othar (Specify) edicai Certification: To 1 ☐ Yas 2X No 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Dascriba how injury occurred 5 Pending Investigation 1 Natural 1 Yes 2 No 2 Accidant 6 Could not be 28a. Place of Injury - At homa, farm, streat, factory, offica building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

of Vital Records, Physicien: i or Attending P Division nerel Director: A To the Hospital within 24 hours a To the Funeral Completaly filled

Box 68760.

P.O.



30. Name and address of person who complated causa of death (Item 23a) (Type, Print) George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. #D Lanham, MD 20706

31. Data filed (Month, Day, Year) JUN 2 9 2000

29b. Signature and title of certifier

29a. Certified (Check only one)

32 Registrar's Signature

***Certifying Phyeician: To the bast of my knowledge, death occurred at tha time, data and placa, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) and manner stated.

29c. Licansa number

039550

29d. Data signad (Month, Day, Year)

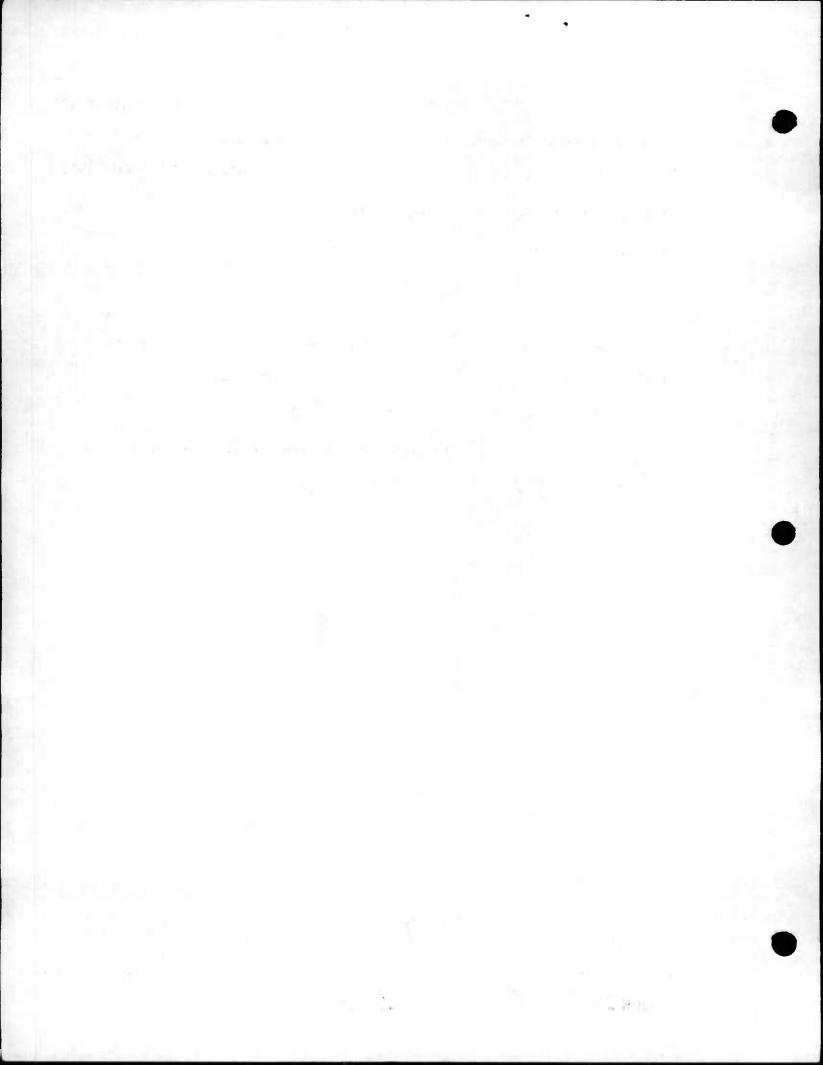
June 28, 2000

JUN 2 9 7000 _ 6- - - 6 _ 46-2-05

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death **Physician** Month Bobby Jones June 2000 8:45PM 26 /Medical 4a. Facility Neme (If not institution, giva street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Prince George's Fort Washington Fort Washington Hospital | If Under 1 Year | If Under 24 Hrs. | S. Date of Birth (Month, Dey, Year) | May 25,1931 5. Social Security Number 7. Aga (In yrs. last birthday) 9. Birthpiace (Steta or Foraign Country)
Tulsa, OK. **Funeral ₩**₩ 2□ F Months 440-28-3213 Yrs. Director 69 Usuei Residance of Decedent death with the Maryland 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be nothined at 10d. tnsida City Limits 1 Yas 2 No Maryland Prince George's Forest Heights Directo 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? USA 151 Onondaga Drive Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Wes Decedant Evar in U,S. Armed Forcas? 11 Marital Status 14. Raca - Amarican Indian, Black, Whita, atc. permit. Peges 1 end 2 should be filed within 72 hours effer to Department of Heelih and Mentel Hyglene. Important: If item 27 is marked other than "natural", or item any injury or other traumatic event, the Medical Examine page. Armed Forcas:
1XXYas 2 No Retired
If Yas, Giva
Yeer or Datas: 1971 1 Nevar Married Married Baltimore, Maryland 21215-0020 Specify: Black 1 ☐ Yas 2 ▼ No Specify: à 3 ☐ Widowed 4 ☐ Divorced 16a. Dacedant's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 15. Dacadant's Education (Specify only highest grada complated) 16b. Kind of Businass/Industry Eiamantary/Secondary (0-12) Coilega (1-4or 5+) US Air Force Military 12th 17. Fathar's Nema (First, Middla, Last) 18. Mother's Nama (First, Middla, Maldan Sumama) Leulah Kidd Willis Jones 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Same as item 10 Denise G. Jones/Wife 20b. Place of Disposition (Nama of 20a. Method of Disposition 20c. Location - City or Town, State Data cametery, crematory or other place) XXBurial 2 ☐ Cremation 3 ☐ Ramoval from Stata Arlington Nat. Cemetery7/5/2000 Arlington, VA. 4 ☐ Donation 5 ☐ Other (Specify) Ceorge P. Kalas Funeral Home, P.A. e of Funeral Service Ligenses 6160 Oxon Hill Rd. Oxon Hill, Md. 20745 Part 1. Enter the disease, or complicetions that caused tha death. Do not antar tha mode of dying, such es cardiac or respiratory arrest, thock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician Cardiac /Medical Immediata Causa (Final disease or condition rasulting in death) Examiner Examiner ettending physician end for use as the buriel-transit The lew requires that the deeth certificate be exacuted Sequentially list conditions, if eny, laading to immadiata cause. Entar Undarfying Cause (Disaase or injury that initieted evants rasulting in daath) Lest Division of Vital Records, P.O. Box 68760. Diabe Physician/Medical Due to (or es e consequanca of): Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert i. been signed by the should be detached 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Dementia þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performad? Completed 1 Yas 2 No 1 □ Yas 2 □ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes casa rafarrad to medical axaminar? 26. Placa of Daath (Check only one) 1 Yes 2 No Othar: 4 Nursing Homa 5 Residence 8 Othar (Specify) Certification: To 1 Dinpatiant 2 □ ER/Outpetienf 3 □ DOA 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. injury at Work? 28d. Describe how injury occurred 1 Neturel 5 Pending 1 ☐ Yas 2 ☐ No invastigation 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Straat and Number or Rural Route Number, City or Town, State) 28a. Place of injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 - Homicida 16 Certifying Phyaictan: To the best of my knowledga, daath occurred et the tima, data and place, and dua to tha cause(s) end mennar as stated.
2 Medical Examinar: On tha basis of examination and/or invastigation, in my opinion, daath occurred at tha tima, data and placa, end due to the causa(s) and manner statad. 29e. Certifier Medical (Check only one) 29b. Signatura and fittle of certifier 29c. Licansa number 12000 Convaso 0051913 30. Nama and addrass of person who complated cause of deeth (Item 231) (Type, Print) Roag 6196 CHARY BEJJENKI. S. H HD-20745 OXON MILL 31. Deta filad (Month, Dey, Year) 32. Registrar's Signative JUN 2 8 2000 Registrar



Please Type or Print In Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Day 2000 ear Month **Physician** 25 2:45pm June JONES GRACE /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner ADVENTIST HOSPITAL Takoma Park Montgomery WASHINGTON If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1□ M 2| F Yrs Director 578 26 8704 8/6/1919 North Carolina **Usual Residence of Decedent** 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** NE Yes 2 No Director Park Takoma Md. Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 "natural", or Nama 23a or 20912 U.S.A. 7620 Maple Avenue Funeral 12. Wes Decedent Ever in U,S.
Armed Forces?
1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. pernit. Peges 1 and 2 should be illed within 72 hours efter of Department of Heelth and Mentel Hygiene. Important: If Item 27 ie merked other than "natural", or her eny injury or other treumetic event, the Medical Exercities. 1 ☐ Never Married 2 ☐ Merried Black Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ 3€ Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th House Keeper Domestic 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) 8 Fannie Jenkins Frank Justice 19a. Informant's Neme/Retetionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stata, Zip Code) Fowler, Friend 1377 Downing St.N.E. Wash. D.C. 20018 Α. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete Dete W Buriat 2 ☐ Cremetion 3 ☐ Removet from Stata 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Park 6/29/00Landover, Maryland Ruth C. Hall HALL BROTHERS FUNERAL HOME 621 Florida Ave., NW, Washington, DC. 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician Immediate Cause (Finat disease or condition resulting in death) /Medical oneumonik Examiner Dua to (or as e consequence of): Physician/Medical Examiner Cegtroperesis or Attending Physicien: The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760, Due to (or es a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Dtd tobacco use contributa to the cause of death? á 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ Completed 24b. Ware autopsy findings eveitable prior to completion of cause of death? 24a. Wes an autopsy performed? 1 Yes 20 No certificate 1 ☐ Yes 2 ☐ No After this certifical funeral director, i Be 25. Was case referred to medicat examiner? 26. Place of Deeth (Check only one) Hospitel: Impatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Othar (Specify) Medical Certification: To 1 Yes 2 No 27. Manner of Death 28a. Data of tnjury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 5 Pending investigation s efter deeth. 1 Yes 2 No 2 Accident 6 Could not be detarmined 3 Suicide 28f. Location (Street end Number or Rural Routa Number, City or Town, Stete) 28e. Place of tnjury - At homa, tarm, street, tectory, office building, atc. (Specify) filled in by 4 Homicide To the Hospital o Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and menner steted. 29a. Certifier completely (Check only one) 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) of person who completed cause of death (Item 23a) (Type, Print)

Elson 6525 Below Hyattsville MD 31. Date tiled (Month, Day, Year) JUN 2 7 2000 32/Registrar's Signature State Registrar

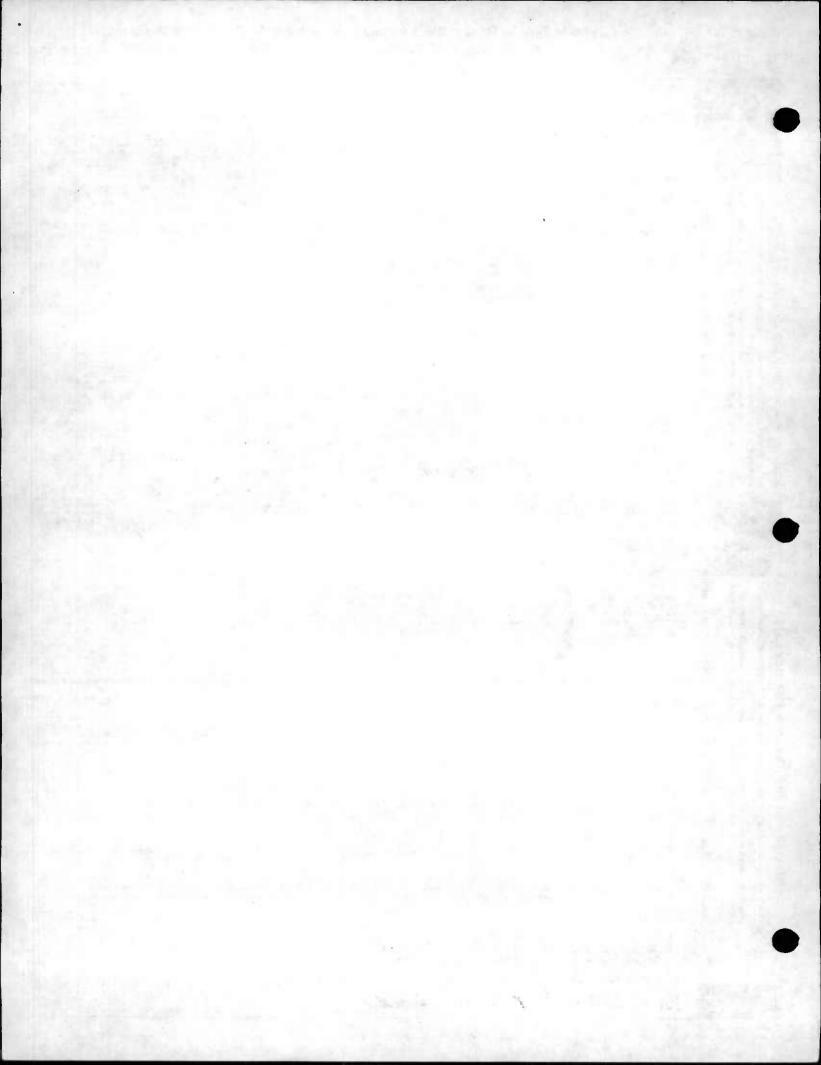
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State of Maryland / Department of Health and Mental Hygiene 00 22252

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State of Maryland / Department of Health and Mental Hygiene

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2017 S A 5100

State of Maryland / Department of Health and Mental Hygiene UU Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Deeth Month **Physician** 2:55PM Norma Beatrice Kelso 2000 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death Examiner Doctors Community Hospital Prince Georges Lanham If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex Days 1□M 2♥F Yrs. 304-26-1522 Sept. 25,1925 Indiana Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 200 S. Southwood Avenue 21401 USA 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-tf Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after d Department of Health and Mental hygiene. Important: If Item 27 Is marked other than "natural", or then any injury or other trausmitic event, pre-medical Emptre 1 Yes 20 No 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Specify: Specify: White Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Vernie Sarles Kate Ferguson 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Pnint) Robert Kelso husband 200 S. Southwood Ave., Annapolis, Md.21401 06-27-00 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition ometery, cremetory or other piece)
Veterans Cemetery 1 Seurial 2 Cremation 3 Removal from State Md. Crownsville, Md. 21. Signeture of Funerel Service Licensee 22. Name and Address of Facility Beall Funeral Home Robert G. Beall M00025 6512 N.W. Crain Hwy., Bowie, Md. 20715 23a. Part 1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death Immediate Cause (Final disease or condition resulting to death) Due to (or as a consequence of): Physician/Medical Examiner ischemic allacks Utible Transient Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Lest Due to (or es a consequence of): physician s the burial Congestive failure . heart Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 ☐ Unknown by 24b. Were autopsy findings Completed 24a. Was an autopsy available prior to completion of cause of death? performed 1 ☐ Yes 2 ☑ No 1 Yes 2 No 25. Was cese referred to medicel axaminer? Be 26. Place of Death (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Certification: To this 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 [Z] Netural 5 Pending 1 Yes 2 No after death. Investigation 2 Accident Director 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of tnjury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b Medical 29a. Certifier 14 Certifying Phyaician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. (Check only 29b. Signature end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 6/287 W DO50514 MIR 5 30. Name end address of person who completed ceuse of death (Item 23a) (Type, Print) Harrisud. MA, cuite 210, fiverdale 65710 14 nilworth ave. 32 Registrar's Signature

DHMH 16 Rev 6/95

20737

Funeral Director

Physician /Medical Examiner

that the death certificate be executed Box 68760 P.O. or Attending Physician:

Division of Vital Records,

State of Maryland / Department of Health and Mental Hygiene 22255

Physician /Medical Examiner Funeral Director

To Be Completed by Funeral Director

Baltimore, Maryland 21215-0020 **Physician** /Medical

charlotte Knox

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Division of Vital Records, P.O. Box 68760

Examiner Physician/Medical Examiner Be Completed by Medical Certification: To

				Ce	rtificat	e of	Death			Re	g. No.			
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that initiated event- resulting in death)	S	d	Dua to (d	ras a consec	quence of):									
Part II. Other signit		ons contributing to d	leath but not ras	ulting in the u	indarlying o	causa gi	van in Part	l.	23	b. Did tol	.1		to the cause of death	

Mental retardat	ion			- 10.100	Today Agonalon
				24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No
25. Was casa refarred to medicai			26. Place of D	eath (Check only ona)	
axaminar?	Hospital: 1 Inpatient 2	☐ ER/Outpatient 3☐	DOA Othar: 4 Nursing	Homa 5 ☐ Rasidanca 6 ☐ Oth	nar (Specity)
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3 Suicida 6 Could not be determined	28a. Place of Injury - At h building, etc. (Speci	noma, farm, straat, fac	tory, office	28f. Location (Street and Numb City or Town, State)	ber or Rural Routa Number,
				ce, and dua to the cause(s) and mourred at the time, data and place,	
29b. Signatura and titla of certifiar			29c. Licansa number	29d. Data signa	ad (Month, Day, Year)

State Registrar

125674

29d. Data signed (Month, Day, Year)

30. Name and address of person who completed causa of death (ttem 23a) (Type, Print) Cockey, M.D.

100 Power Street

21804 Salisbury, MD

31. Data filed (Month, Day, Year)

32. Registrar's Signatura

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Date of Death 3. Time of Death Day Month Year KNIPPLE **Physician** JOHN KANCIS 26 1:58 A.M. 2000 lune /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and num 4c. County of Death Examiner Baltimore HODKINS lospital ohns If Under 24 Hrs. Hours Min. If Under 1 Year 8. Date of Birth (Month, Day, Year) Jun 27, 1 5. Social Security Number 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** Days Hours Months 1 M 2 F 219-34-5744 Yrs. 1938 Director 61 Maryland Usual Rasidance of Dacedant with the Maryland 10c. City, Town or Location 10a. Sfata 10b. County 10d. Inside City Limits Health and Mental Hygiene. Item 27 Is marked other than "natural", or Items 23s or 28s-f show other traumstic avant, the Medical Examinar matal be notified at Maryland Frederick Frederick 1 ☐ Yas 2X No **Funeral Director** 10e. Sfreef and Number 10f. Zip Coda 10g. Citizen of What Country? 7744 Kemp Lane 21702 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14. Race - American Indian, Black, White, atc. 12. Was Decedent Ever in U,S. Armed Forcas? permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: if Item 27 ia marked other than "natural", or ite any injury or other traumatic avant, the Medical Exempton. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify. White Specify: þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grada completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b Kind of Business/Industry Elemantary/Secondary (0-12) 12 College (1-4or 5+) Assitant Chief Dispatcher Emergency Communications 17. Father's Name (First, Middle, Last) 18. Mofher's Name (First, Middla, Maidan Sumama) Be John Eli Knipple Magdalene Lillian Gilbert 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Ralationship (Type, Print) Katherine Knipple/Wife 7744 Kemp Lane, Frederick, Maryland 21702 20b. Place of Disposition (Nama of cemetery, cremetory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from State Mt Olivet Cemetery Jun 29, 2000 Frederick, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) ²² Nama and Addigess of Facility
Keeney & Bastord P.A. Funeral Home 21. Signature of Funeral Service Licensee Kobe son MO0706 106 East Church St, Frederick, Maryland 21701 23a. Part1. Enfair the diseasa, or complications that caused the death. Do not enter tha mode of dying, such as cardiac or respiratory arrest, shock, or haart failure. List only one cause on each line. Approximate Interval Batwaan Onsat and Daath **Physician** /Medical Immediate Cause (Final SCHEMIC 15 YEARS ARDIOMYOPAT diseasa or condition resulting in death) Examiner Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or as a consequenca of): and physician a Box 68760. Physician/Medical Due fo (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. P.O. signed by t 1 Yes No 3 ☐ Probably 4 ☐ Unknown Records, þ 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of death? hes 2X No 2X No certificate of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA this funeral ours after death.

Neral Director: After the 28d. Describe how injury occurred Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? or Attending 1 Natural Division 5 Pending investigation 1 Yes 2 No 2 Accidant 6 Could not be 3 Suicida 28f. Location (Street end Number or Rural Routa Number, City or Town, State) 28a. Placa of Injury - Af homa, farm, sfreet, factory, office building, atc. (Specify) 4 Homicida To the Hospital within 24 hours a To the Funeral Completely filled 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edicai 29a. Cartifiar (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year) JUN 2 8 2000

MICOL ROTHMAN JOHNS HORMS HOSPITAL BALTIMORE, MD 21705 32. Regisfrar's Signatura

30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print)

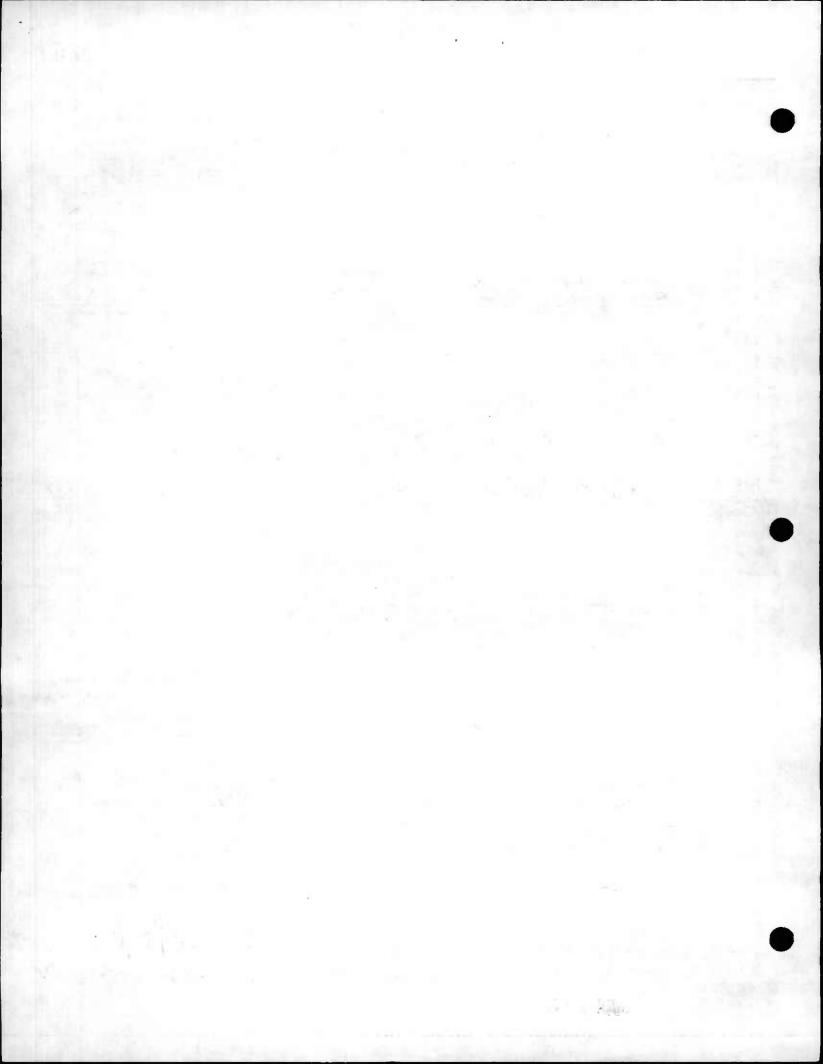
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/Medical xaminer	4a Facility Name (If not institution, give	T WENT VII	KACIII		4b. City, Town, or L						
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neral	5. Social Security Number 6. Se	⊓u abore	s. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th y, Year)	Birthplaca (State or Country)			
ector	Usual Residence of Decedent	89	110.			6-30	-11	PA.			
4	10a. State -10b. County	10c. C	city, Town or Loc	ation				10d. Inside City			
De normed Director	MD WORCEST	TER OC	EAN PI	NES				1 XYes			
remarks of 2841 show	10e. Street and Number			10f. Zip Code			10g. Citizen of V	What Country?			
must	33 BATTERSEA CI	12. Was Decedent Ever in I	110 112 14	21811	dianania Origina / Se	anifu Van as Na	US	A - American Indian,			
ricer must. Funeral	11. Merital Status 1 □ Never Merried 2 □ Married	Armed Forces?	0,5. 13. W	Yes, specify Cub	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	Blac	ck, White, etc.			
by	3 ☑ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	11	Yes 2000	Specify:		Specify	WHITE			
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mple	Elementary/Secondary (0-12)	College (1-4or 5+)	_		during most of world)	9	_				
la marked oth raumatic even	17. Father's Name (First, Middle, Last)	6	GUIDA	NCE COL	18. Mother's Nam	a (First Middle	EDUCAT				
			0	, maiden Sumen	10)						
	JOHN E. BEDDOW 19a. Informent's Name/Relationship (T)	PEARL and Number or Ru	SOBEY	er, City or Town,	State, Zip Code)						
	JOHN KACHEL	SON	77 5	ATTERSE			PINES,				
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	4 Donation 5 Other (Specify)		D FELLO	OWS CEM	ETERY 7	-3	FRACKV	ILLE, PA.			
	21. Signature of Funertal Service Licens	300		Name and Addre							
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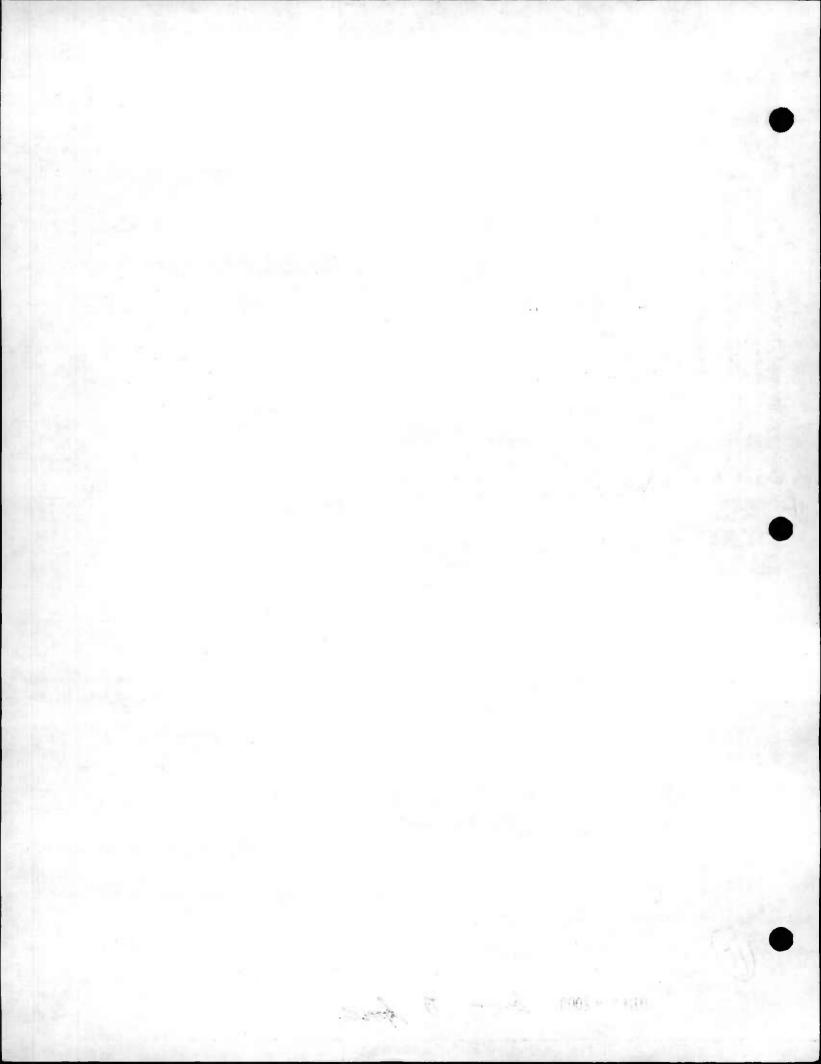
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 0 0 22258

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/Medi		Eleanor P. Lew						June		000	9:43AM				
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Via Ment Ment		Charles Washi	0				Ma	ry Neal							
M d 2		19a. Informant's Name/Ralationship (Type, Print) Eduardo Potillo – Grandson 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code, 4378 Dubois Pl., S.E. Wash., D.C. 20019													
Ballimore, semil. Pages 1 er popartment of Hae moortant: If Nem 3 my Injury or other most.		20a. Mathod of Disposition 1													
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Physician /Medical Examiner	er	23a. Part I inter the disease, or com- shoot or heart failure. List only Immediate Causa (Final disease or condition resulting in death)			and the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of t	Intarval Batween Onsat and Death									
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OI VICE Physicien: this certific ral director,	10	axaminar? 1 ¼ Yas 2 ☐ No	Hospital: 1 Inpatia	nt 2 ERVO	utpatient 3 🗆 E	O AO	her: 4 Nursing	Homa 5 🗓 Rasio	dance 6 Oth	ar (Specify)				
Attending Phy or death.	atlon:	27. Mannar of Death 1 Natural 5 Panding 2 Accidant invastigatio	28a. Data of Injur (Month, Day	Year) 28b.	Tima of Injury M	28c. Inje We 1	ry at ork?] Yas 2 ☐ No	28d. Describe I	now injury occurr	ed					
A A A	Certification:	3 Suicide 6 Could not be detarmined		ry - At homa, f . (Specify)	arm, street, facto	ry, office		28f. Location (S City or Tox	Street and Numb vn, Stata)	er or Rural	Routa Number,				
To the Hospital or Atl within 24 hours after of To the Funeral Direct completely filled in by	edical (29a. Cartifiar (Check only one)	yelclen: To the best on inner: On the basis of and mannar sta	axamination at	a, death occurre nd/or invastigation	d at the t n, in my	ima, data and plac opinion, daath occ	e, end dua to tha curred at tha tima,	causa(s) and ma data and place, (nner as stand dua to	ated. tha cause(s)				
ro th comp	M	29b. Signatura and title of pertiller		>	2	9c. Licer	se number		29d. Data signed	d (Month, L	Day, Year)				
- 3)	1/5				1	0324	97	_						
(10)	/	30. Nama and addrass of person who			(Type, Print)				June 28						
		Patricia Dav			ng St.,	N.W.	; #118,	Wash., D	.C. 200	010-2	2975				
Sta Regist		31. Data filed (Month, Day, Year) JUN 2 9 2000	32. Hegistra	r's Signatura	1										

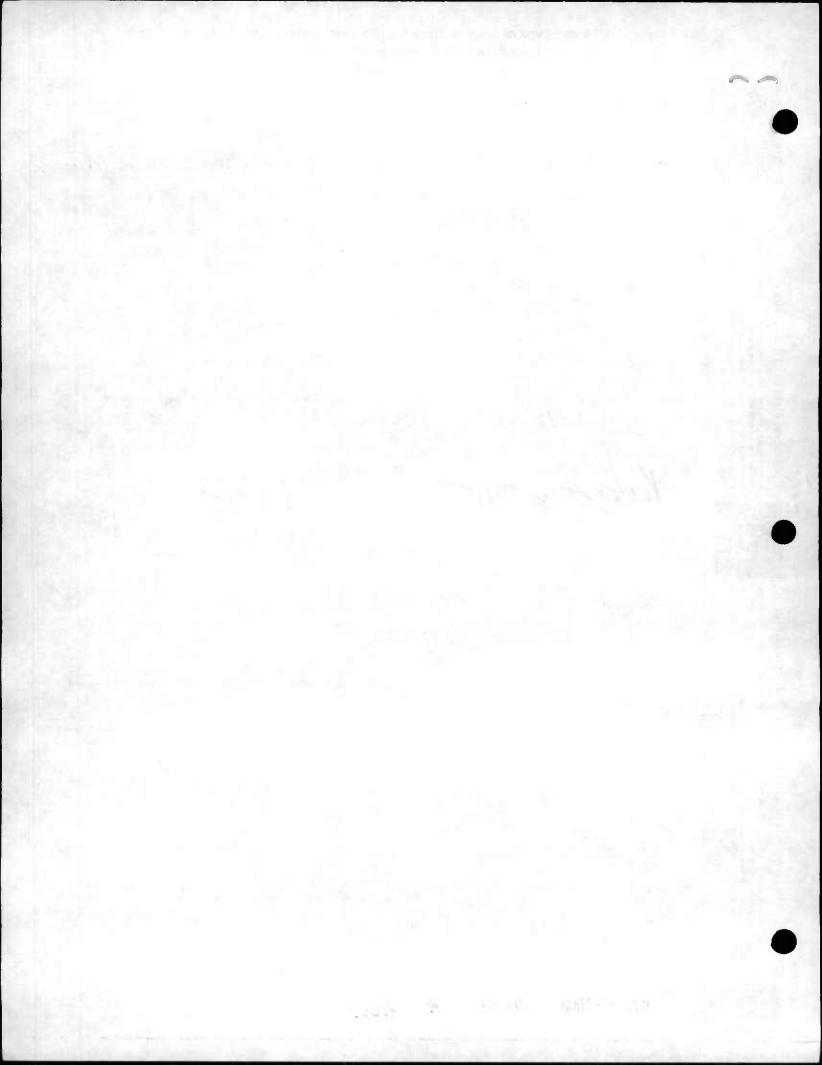
DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene

				Cei	rtificate	of I	Death			Reg. No.	U	22259	
	1. Decedent's Name (First, Midd	lle, Last)	USS SET						2. Deta of De		Yaer	3. Tima of Death	
Physician /Medical	WILLIAM GAR	FIELD LYTI	LE							22,2000	1961	10:30pm	
Examiner	4a Facility Name (If not institution PRINCE GEORGE)					4	b. City, To		cation of Deat			EORGES	
Funeral Director	5. Social Security Number 578-66-2902	6. Sex 1)∑ M 2□ F	7. Age (In yrs. I 51	ast birthdey) Yrs.	If Under 1 Months	Year Deys	If Undar Hours	24 Hrs. Min.	8. Date of Bir (Month, De APRIL	th Year) 23,1949	9. Birth Cou WASI	pleca (Stete or Foreig ntry) HINGTON DC	
un with the Maryland 23e or 28e-f show ust be notified at ral Director	Usual Residence of Decedent 10a. State 10b. Count MD PRINCI	GEORGES		v, Town or Lo	cation							10d. Inside City Limit	
288 Double	10e, Sfreef and Number				10f. Zip C	ode	-		10g. Citizen of What Country?				
3a or	1213 PARKINGTON	J LANF			20	716			30	UNITED STATES			
r hams 23 kiner must Funeral	11. Merital Status		edent Ever in U,	S. 13.		nt of H	ispanic Ori	igin? (Spe	city Yes or No	o- 14. Re	ca - Ameri	can Indian,	
by by	1 ☐ Never Married 2 ☐ Mai 3 ☐ Widowed 4 ☐ Divorce	ried 1XXYea	2 □ No iva		1 ☐ Yes 2X		Specify:		nican, etc.)		ck, White, by: BLA		
ygiere. yet the fraction of the Medical	(Specify only higher Elementary/Secondary (0-12)	nt's Education est grade completed, College	1-4or 5+)	(Give life. I	dent's Usual kind of work DO NOT use	done d	during mos I)	t of worki	ng	16b. Kind of E		dustry	
0 485	12 17. Fathar's Name (First, Middle	(act)		ROUT	E SUPE	ERVI		ar'e Nama	/Firet Middle	PRIV , Meidan Suma			
Pages 1 and 2 should be ment of Health and Mental ant. If flem 27 is mented o lury or other traumatic ev	WILLIAM G. I	YTLE SR					MAI	RGARE	T MORG	AN			
	19a. Informant's Name/Relation			er, City or Towr	-300								
	WILLIE ANN LYT 20a. Method of Disposition	LE/SISTER		5014 laca of Dispo			RD, (CAPIT	OL HEI	GHTS, MD 20c. Location			
	1 Buriel 2 Cremetion 4 Donetion 5 Other (5	Specify)	State C	emetery, crer RYLANI	NATION NATION	onA.	L CEM		Y 6-29-	-00 LAU	JREL,		
	21. Signature of Funeral Service	Marc M	118						POPE FUNERAL HOME E,FORESTVILLE,MD 20747				
5 C-10	23a. Part1. Enter the cash shock, or heart failure.	compositions thet	caused the death								10 20	Approximate Interval Between	
Medical Examiner used to see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see the see t	fmmediate Cause (Final disease or condition resulting In death) e. CM(IMM & LVV 6 Due to (or as a consequence of):												
ling physicie e as the bur Medical	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disesse or injury that initiated events resulting in death) Lest	c		r as a conseq				1					
2 6 5	Pert II. Other significant conditi	one contributing to	leath but not ree	ilting in the u	nderbring car	uee div	en in Part		23h Did	tobacco use co	ontribute !	o the cause of deat	
d by the letach	Pet II. Other significant coroni	one contributing to c	eath but not rest	ating in the u	ndenying car	use giv	en miratt			23b. Did tobacco use contribute to the cause of death 1 Yes 2 No 3 Probably 4 Unknown			
s been s 2 should pieted		332								s en eutopsy ormed?	6.	Vere autopsy findings veileble prior to completion of causa death?	
page 2									10	Yea 20 No	1	Yes 2 No	
certificate rector, pag	25. Was case referred to medica examiner?		/				26. Place	e of Death	(Check only	one)	1		
2 00 0	1 Yes 2 No			ER/Outpatier		-	4 LI N	ursing Hor	me 5 Res	idence 6 🗆 Ot	her (Spec	ify)	
After After I	27. Manner of Death 1 Natural 5 Pendi 2 Accident invest 3 Suicide 6 Could	igation not be	nth, Dey Year)	28b. Time of Injury	М		yat k? Yes 2□	No		how injury occu			
us after deat rei Director: lled in by the Certifica	4 Homicide	nined 200. Plac	a of Injury - At ho ling, etc. <i>(Specif</i>)	ome, farm, str	reet, fectory,	office			City or To	(Street end Num own, State)	nper or Rui	ral Routa Number,	
Within 24 hours after Completely filled in Medical Cert	(Check only 2 Medical one)		e best of my know easis of examinat oner stafed.	wledge, death ion and/or in-	vestigation, i	n my o	pinion, dea	nd place, a ath occurre	and due to the ed at the time	, date and place	, and due	to the cause(s)	
To the comple	29b. Signatura and fitle of certific	" 1001	1	INW	29c.	Licens	e number	()		29d. Date sign	ed (Month	Dey, Year)	
1/4/	1 Nul 9/1/ (20 6-26-00									0			
	30. Name and address of person	who completed cau	se of death (Item	23a) (Type,	Print) Ord	V) r	La	urel	mo	20	8050	
State Registrar	31. Dete filed (Month, Day, Year JUN 2 9 20		Registrar's Signa	ture .	long se	,							

DHMH 16 Rev 6/95



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] Certificate of Death 1. Decedant's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Thomas Frank Lusby II, M.D. Jume 29 D2000 Yaer 1205 AM 4a. Facility Nama (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 6200 Sandy Point Road Prince Frederick Calvert 7. Aga (In yrs. last birthday) H Undar 1 Yeer H Undar 24 Hrs. 8. Date of Birth Aga Yrs Months Days Hours Min. F Month Day, Year 17 5. Sociel Security Number 6. Sax 9. Birthplace (Stata or Foreign 1 M 2□ F Maryland 220 44 2280 Usuai Rasidanca of Decedan 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits Maryland Calvert 1 Yas 2 No Prince Frederick 10a Street and Number 10f. Zip Code 10g. Citizen of What Country? 6200 Sandy Point Road 20678 United States 12. Was Decedant Ever In U,S. Armed Forcas? 11 Maritei Stetus 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Ricen, atc.) 14. Rece - Amarican Indian Bleck, Whita, atc. Y□Yes 2□No If Yes, Give 1 Navar Mamled 2 Married white 1 Yas 2 No Specify: Specify: 3 Widowed 4 Divorced Year or Dates: WWII 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry Eiamantary/Secondary (0-12) Coilega (1-4or 5+) Medical doctor Health care 17. Fether's Name (First, Middla, Last) 18. Mother's Nama (First, Middla, Meiden Surnema) Maurice T. Lusby, Sr. Lillian Bowen 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code, Thomas F. Lusby III, D.D.S.6190 Sandy Pt. Rd. Prince Frederick MD 20e. Mathod of Disposition 20b. Place of Disposition (Nama of Typlace) 1y 3, 2000 20c. Location - City or Town, Stata 1 ⊠ Burial 2 ☐ Cremetion 3 ☐ Ramoval from State St. Pauls Episcopal CemeteryPrinceFrederick Maryland 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Funaral Service Licansee 22. Nema end Addrass of Facility Rausch Funeral Home PA Blowse 4405 Broomes Is. Rd. Port Republic M 20676
23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximata Intarval Batween Onsat and Death Immediata Cause (Final disaasa or condition rasulting in death) CARDIAC ARRHYTHMIA Few menuts Due to (or as a consequence of): HEART DISEASE ATHEROSCLEROTIC Dua to (or as a consequence of): Due to (or es a consequence of): 23b. Did tobacco use contribute to the cause of death? Left Cerebrovascula 1 Yes 2 No 3 Probably 4 Unknown .C.6171 24b. Wara autopsy findings available prior to 24e. Wes an autopsy completion of ceusa of deeth? Bruch

Physician /Medical Examiner

physician and s the burial-transit

attending p for use as

The law requires that the death certificate be executed

Box 68760.

P.O.

Records.

of Vitai

Division

Hospital or Attending Physician:

this

within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral of

Physician /Medical

Examiner

Director

Funeral

þ

Completed

Be

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Examiner

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Completed

Be

2

Certification:

Medical

Funeral

Director

77 is marked other than "naturel", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "naturel", or ite, eny injury or other traumetic event, the Medical Exempton

Saltimore, Maryland 21215-0020

death v

Sequantially list conditions, if any, laading to immediata cause. Entar Underlying Cause (Diseasa or injury Physician/Medical thet initiated events rasulting in daath) Lest

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.

6 C) Could not be

1 Yes 2 No 26. Placa of Daeth (Check only one)

1 Tyes 2 □ No

25.	examinar?	
	1 Yas 2N No	
-		-

1 (Watural 5 Pending investigation 2 Accident

28a. Data of Injury (Month, Day Year)

1 inpatiant 2 ER/Outpetlent 3 DOA 28b. Tima of 28c. Injury et Work?

Other: 4 Nursing Homa 5 Assidance 6 Other (Specify) 28d, Dascribe how Injury occurred

28f. Location (Streat and Number or Rural Route Number, City or Town, Stata)

29e, Certifier (Check only onel

3 Suicide

4 Homicide

10 Certifying Physician: To the bast of my knowledge, deeth occurred at the time, dete end place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated.

29c. Licansa number

29b. Signatura end titla of certifiar

MD. Physicin

28a. Piace of Injury - At homa, farm, street, fectory, office building, etc. (Specify)

19427

1 Yas 2 No

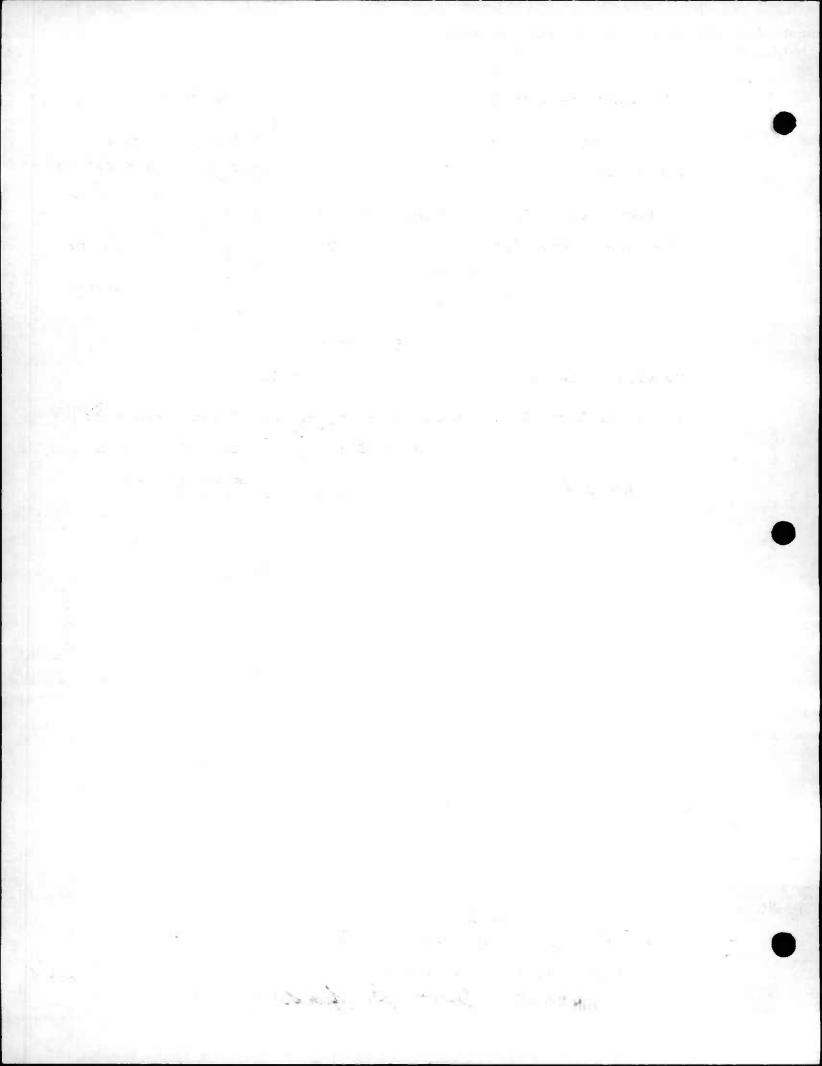
29d. Data signed (Month, Day, Year)

30. Nama and address of person who complated causa of daeth (item 23a) (Type, Print) ANWAR MUNSHI M. D She 303

110 HOSP Road Primes Frederic MD

State Registrar

JUN 3 0 2000 Registrar's Signature 31. Data filed (Month, Day, Year)



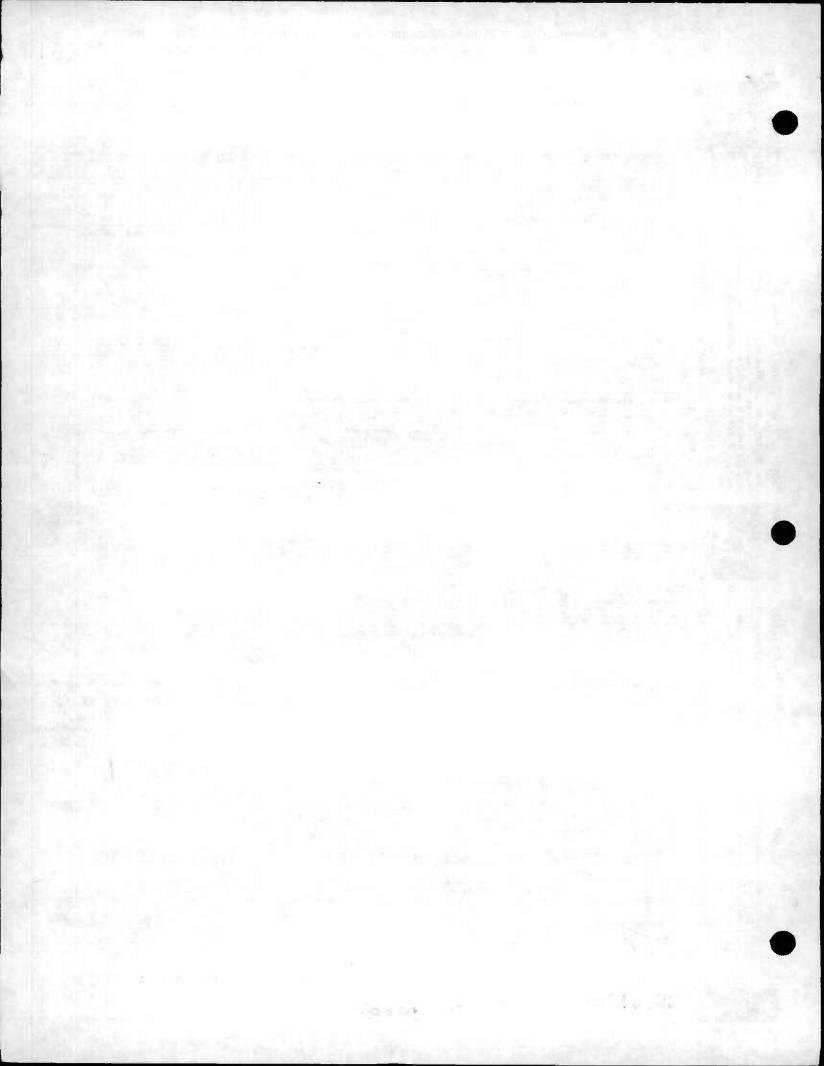
CANDELA

RIO MARTINEZ-RAMOS State of Maryland / Department of Health and Mental Hygiene 222 amend item 23a,27,28a.b.c.d.e.f per me G785 7/14/00 @ertificate of Death			
	©ertificate of Death Reg. No.	mend item 23a,27,28a.b.c.d.e.f	amend

	cem 23a,27,28a.b.c.d.e					2. Data of De			3. Tima of Death			
Physician	CANI	ELARIO M	ARTINEZ-	-RAMOS		JUNE JUNE	Day 28	Yaar 2000	18:19 PM			
/Medical Examiner	4a Facility Nama (If not institution,	giva street and number)	12.192	4b. City, Town, o	Location of Deat	h 4c. County	of Death				
	11903 CENTERHIL	L ROAD			WHEATON		MONTO	OMERY				
Funeral Director	Unknown	6. Sex 7. A	ge (in yrs. last b 34	Yrs. If Under 1 Months I	Yaar If Undar 24 Hr Days Hours Mir	. (Month, Di	rth ay, Year) , 1966	9. Birthpla Country E1	ce (Stata or Foraign y) Salvador			
www.	Usual Rasidence of Decedant 10a. Stata 10b. County		10c. City, To	vn or Location				100	d. Insida City Limits			
death with the Maryland ma 23a or 28a-f show if must be nothfied as neral Director	Md. Mont	gomery	Wheat	on					Yas 2□No			
vith the Ma	10e. Street and Number			10f. Zip C	oda		10g. Citizan of	What Country	y?			
23a	11903 Cente	r Hill Stre	eet		20902		E1 Sa					
P 22 5	11. Marital Status 1 □ Nevar Married 2 ☑ Marrie 3 □ Widowed 4 □ Divorced	12. Was Decedani Armed Forcas ed 1 Yas 2 Harar Yas, Giva Yaar or Datas:	? KNo		nt of Hispanic Origin? (Cuban, Maxicen, Pus		Bla	n Indian, c. panic				
netural.	15. Decedent		16	Decedent's Usual (Occupation	advina	16b. Kind of B	usinass/Indu	stry			
e filed within 72 hours ef al Hygione I Hygione corber than "natural", or vent, the Hedical Exerci-	(Specify only highast Elemantary/Secondary (0-12) 3 rd	College (1-4or	5+)		done during most of w retired) SCaper	orking						
d 2 should be filed th and Mental Hygi th and wetal Hygi teumetic event, To Be Co	17. Fathar's Nama (First, Middla, L	ast)			-	ama (First, Middle	a, Maidan Sumar	na)				
ges 1 and 2 should be filed to the Hosth and Mental Hyg if item 27 ta marked other or other traumatic event,	Felis Martine	Z	1		Greg	oria Ram	os					
2 should by and Menta le merked eumetic ev	19a. Informant's Name/Ratationsh				Street and Number or i							
fealth m 27	Cristina Me	ndoza Marti		1190 of Disposition (Nama	3 Center H							
emit. Pages 1 ar Pepartment of Hea mportant: if item iny Injury or othe MGs.	20a. Mathod of Disposition 1 Kurial 2 Cremation		cemat	ary, cramatory or oth	ar place)	Data	20c. Location					
rtmer rtant: njury	4 Donation 5 Other (Sp	• • • • • • • • • • • • • • • • • • • •	Fa	mily Ceme		0/-10-0	USangero	lo, El	Salvador			
permit. Pages 1 and Department of Health Important: If Idem 27 any Injury or other ti pnce.	21. Signature of Funeral Service Licensea Wanda C. Bacon CC036/ BACON FUNERAL HOME, INC. 3447 14th St Washington, D. C. 20010											
	23a. Part1. Entar tha disaasa, or shock, or haart failura. List o				gton, D. C	. 20010	J447 140		Approximata			
Physician /Medical Examiner	fmmediata Causa (Final disease or condition resulting in death)	a. ISOPROPA	NOL INTOX Dua to (or as a	ICATION consequence of):								
be assecuted ician and buriel-transit	Sequentially list conditions, if any, laading to immadiate cause. Enter Underlying Cause (Disease or injury		Dua to (or as a	consaquance of):					/			
ing phys a as the	rasulting in death) Last	d	Dua to (or as a	consequance of):								
at the death ce d by the attendia eteched for use Physician/	Part II. Other eignificant condition	ne contributing to death	but not rasulting	in the underlying cau	isa givan in Part f.	23b. Did			the cause of death?			
						1	Yee 2 No	3 Probe	ably 40 Unknow			
been s should	, , , , , , , , , , , , , , , , , , , ,						s an autopsy formed?	avai	ra eutopsy findings ilabia prior to optation of causa eath?			
Physician: The law requires the this certificate has been signed rail director, page 2 should be call. To Be Completed by						1 12	Yes 2□No	15	Yas 2□ No			
ysicien: The secondificate director, par	25. Was casa rafarred to medicat examinar?					aath (Check only	ona)		1			
his his	1 □XYas 2 □ No	Hospital:	1	Outpatient 3 DOA		Homa 5□ Ras						
After fune fune	27. Mannar of Death 1 Natural 5 Panding 2 Accident invastig	ation 10dild 6/2	ay Year) 8/2000 fou	Tima of P 286	c. Injury at Work? 1 ☐ Yas 2 🖾 No		how injury occu					
	3 ☐ Suicida 6 🗷 Could n 4 ☐ Homlcida datami	offica	281. Location City or To Wheaton		ber or Aural 03 Cent	Routa Number, erhill Rd.,						
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by Medical Certiff		Phyeician: To the best examiner: On the bests and manners										
within 2 vithe comple	29b. Signature and title of certifier	. 1.	1	29c.		29d. Data signad (Month, Day, Year)						
(2)	Theolonge C.M.E. JUNE 29, 2											
Qy	30. Nama and addrass of person v	the Bausa hatalemos only	death (Itam 23a	(Type, Print)								

State Registrar

32. Registrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 00 22262

			No.	Cei	rtificate (of Dea	ath		Reg. No.	, 0	22206		
an	Decedent's Neme (First, Mid	dle, Last)	Mar No.	To any	F- 115			2. Date of De	the 10ey Year 2331				
	Charles Mona								-	2000	2334		
	4a Facility Name (If not instituti							Location of Deet					
ĺ	The Memori	-		to a to be at a to	If Under 1 Y		Easto Inder 24 Hrs.		Tall				
ı	5. Social Security Number	6. Sex	7. Age (In yrs. 7				ours Min.	(Month, De	th sy, Year)		plece (State or Foreign ntry)		
	220-30-3552 Usual Residence of Decedent			7 110.				Oct. I	8, 1922	Unk	nown		
	10a. State 10b. Count	ly	10c. Cit	y, Town or Lo	cation						10d. Inside City Limits		
	Maryland Caro	line	Go	ldsbor	0						1 ☐ Yes 2 No		
	10e. Street and Number	LINE	GO	Idsbol	10f. Zip Co	de			10g. Cifizen of 1	Whet Cou	ntry?		
	073 Puidos Torm	. D.1											
	973 Bridge Town 11. Marital Stetus Unknow	12. Was De	ecedent Ever in U	.S. 13.	Wes Decedent		nic Origin? (S	pecify Yes or No	USA 14. Rec	e - Ameri	can Indian,		
	1 Never Married 2 Ma	7 1111100	Forces?		f Yes, specify	Cuban, Me	exican, Puerl	pecify Yes or No o Rican, etc.)	Ble	Bleck, White, etc.			
	3 Widowed 4 Divorce	If Yes, 0	Give Dates: Unkn	own	1□ Yes 2□	No Sp	ecity:		Specify: White				
	15. Decede	nt's Education	Leading and the	16a. Dece	ient's Usual O	ccupation		4.6	16b. Kind of B	16b. Kind of Business/Industry			
ŀ	Elementary/Secondary (0-12)	est grade completes College	(1-4or 5+)	life.	kind of work d DO NOT use re	one aunng etired)	g most or wo	King					
l	Unknown			Far	mer				Farmi	ing			
į	17. Father's Neme (First, Middle	e, Last)				18. Mother's Name (First, Middle, Maiden Surname)							
į	Unknown					1 1 1 7	Unkno	wn					
	19a. Informent's Name/Relation	nship (Type, Print)	19b. Mailin	tress (Street and Number or Rural Route Number, City or Town, State, Zip Code									
0 = 0	Carl Burke, (Talbot	B1vd	, Ches	tertown	, Maryla	ind	21620					
	20e. Method of Disposition								20c. Location	City or To	own, State		
	4 Donation 5 Other			apitol	Cremat	ory		6/30/00	Dover,	Dela	ware		
Departmen Departmen Important: any Injury once.	21. Signature of Funerel Service	e Licensee		22			Fecility						
ĺ	21. Signature of funeral Service Licensee 22. Name and Address of Facility Bennie Smith Funeral Home P.O. Box 1687, Easton, Maryland 2160												
1	23a. Pent Enter the disease,	or complications tha	t caused the deat	h. Do not ent						1 21	Approximete		
	shock, or heert failure. Lis	st only one cause or	n each line.								Interval Between Onset and Death		
	Immediate Cause (Final	A	. 40	P.	enal	F	7	ممو		1	15 days		
I	disease or condition resulting In deeth)	a	Due to (o	or as a consec		1 1	4110	J. C		1	100142		
ı		N.								1			
I	Sequentially tist conditions	b. 17	Po to to	or as a consec						1			
	Sequentially tist conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury		000,000		, , , , , , , , , , , , , , , , , , , ,								
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	resulting in death) Last		12.10							1			
		d											
Ī	Part II. Other significant condit	tons contributing to	death but not res	ulting in the u	nderlying caus	e given in	Pert I.	23b. Did	tobacco use co	entribute t	to the cause of death?		
	() ()	0			0		,	10	Yee 2 No	3 □ Pro	bably 4 Nnknowr		
	140040	1264	bina	ton	ا ا	577	e 55						
	7900	1							an autopsy ormed?	24b. W	Vere autopsy findings vailable prior to		
	2) Throw	100 cf 7	- pen	119				pen	oivai	CC	ompletion of cause I death?		
								10	Yes 20No		☐Yes 2☐No		
r	25. Was case referred to medic	at				26	Place of De	ath (Check only			- 100 WELL 110		
	examiner?	Hospital: 3	apatient 2	ER/Outpatier	it 3D DOA	Other:				or /Saas	(h/)		
	27. Manner of Death		e of tnjury onth, Day Year)	28b. Time of		Injury et Work?	- Nursing F		idenca 6 Oth how injury occur		97		
	1 Natural 5 Pend	ing (Mo	onth, Day Year)	Injury	м	Work? 1 ☐ Yes	2 No						
	3 ☐ Suicide 6 ☐ Could	nof be	ce of Injury - At he	ome, farm str				28f. Location	Street and Numi	ber or Rur	ral Route Number,		
Ī	4 Homicide	mined 200. Pla	lding, etc. (Specif	y)	551, 1451517, 51			City or To	wn, State)		712 22 31 31 31 31 31		
	29a. Certifier 1 Certify	ing Physician: To the	na hast of my kno	wladna daatt	occurred at th	ne time de	ate and place	and due to the	causa(s) and m	20000	stated		
		I Examiner: On the	basis of examination	tion end/or in	estigetion, in	my opinior	n, death occu	rred et the time,	date and place,	and due t	to the cause(s)		
l	29b. Signature end title of certifi		pratter stated.		29c. Li	cense nun	nber		29d. Date signe	ed (Month.	Day, Year)		
	A		000	00					. /	. / _			
	Henry	- ME	& other	alexo		053	110		6/29	1/20	000		
	30. Name end address of person	None	ANALEST (SE)			17.3			1				
	Dennis Des		D, 219 9		Vashint	on St	t.,Eas	ton, Mary	yland 21	601			
State ³ Registrar	31. Dete filed (Month, Day, Year		Registrer's Signa		4	1.							
	JUN	3 0 2000	1 Porte		N. 1	your	5						

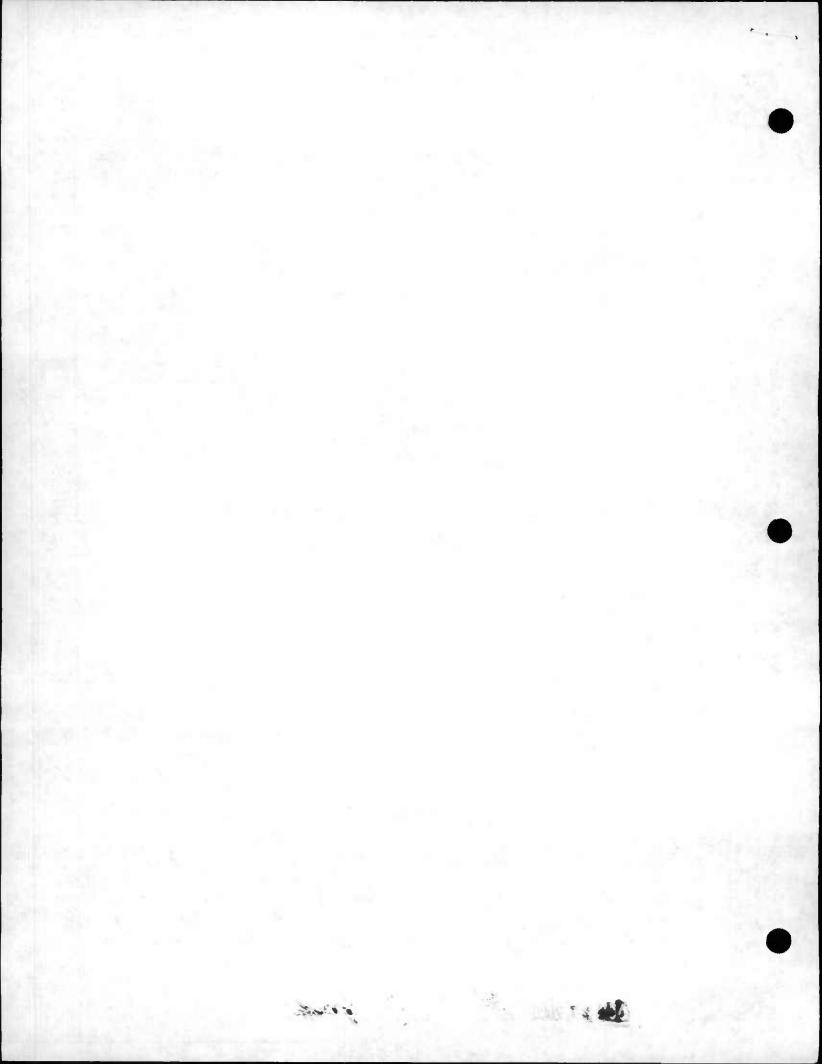
DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Amended line 17,18 fchd jd 1. Decedant's Nama (First, Middle, Last) 2. Date of Death Day **Physician** SARAH ESTHER JUNE 23, 3:05 PM 2000 /Medical 4a Facility Nema (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Frederick Frederick Frederick Memorial Hospital If Under 24 Hrs. Hours | Min. If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Dete of Birth (Month, Day, Year) **Funeral** Months Deys 1□M 2\ F 578-22-9434 Dec. 17, 1911 Virginia **Director** Usuel Residence of Decedent death with the Marylend 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits ahow na 23a or 28a-f ahor 1K Yes 2 □ No Funeral Director Maryland Frederick Frederick 10e Street and Number 10f Zin Code 10g. Citizen of Whet Country? 21702 United States 1900 Rosemont Avenue Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Giva
Yaer or Dates: 14. Race - Amarican Indian, Black, White, etc. Hems Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) other traumatic event, the Medical Examiner Peges 1 and 2 should be filled within 72 hours effer nent of Health and Mentel Hygiene. Int: If Item 27 is marked other than "natural", or ite 1 Never Merried 2 Merried 8 altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: Completed by 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada completed) 16b. Kind of Business/Industry I Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Waitress Restaurant 12 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Fathar's Neme (First, Middle, Last) Be Mary Catherine Maurey Charles Arthur Dyke 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) nt of Health e :: If Item 27 is or other tra Suite 200 Frederick, MD Elizabeth Conklyn, attorney 14 West Patrick St, 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State Department Important: eny injury 6/26/00 Hagerstown, Maryland 4 ☐ Donation 5 ☐ Othar (Specify) Hagerstown Crematory 21. Signeture of Fuperel Service Lipensee 22. Name and Addrass of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, Maryland 21702 ons that caused the deeth. Do not enter tha mode of dying, such as cerdiac or respiretory errest, ause on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or es e consequenca of) Examiner The lew requires that the death certificate be executed the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated avents resulting in death) Last Due to (or es e consequenca of): Box 68760 Physician/Medical Dua to (or es a consequence of) for use P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Records, Completed by 24a. Wes en eutopsy performad? 24b. Were eutopsy findings available prior to completion of causa of death? page 2 hes 1 🗆 Yes 1 Yes of Vital Physician: 25. Wes case referred to medical exeminer? Be 26. Place of Deeth (Check only one) To Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No Hospitel: 2 ER/Outpetient 3 DOA Inpatient this 27. Menner of Death 28e. Date of Injury (Month, Day Medical Certification: 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Division or Attending 1 Neturel 5 Pending investigation death. 1 ☐ Yes 2 ☐ No the within 24 hours after deat To the Funeral Director; 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, farm, street, factory, offica building, etc. (Specify) filled In by 4 ☐ Homicide To the Hospital 1) Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end manner as stated.

2 Medicat Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pleca, and due to the cause(s) end menner stated. 29e. Certifiar completely (Check only one) 29c. License number 29d. Data signed (Month, Day, Year) 29b. Signature and talls of pertifier 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) aytmani 32. Régistrar's Signeture 31. Data filed (Month, Day, Year) State Registrar

DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22264 Amended item#17 FCHD 06/29/2000 KS Certificate of Death 3. Tima ol Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Day Physician Margaret Vivian Meetze June 18. 2000 6:30 AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Sunrise Assisted Living Frederick Frederick Birthplace (Stata or Foraign Country) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Hours Months 1□ M 2CXF Director May 13, 1909 223-60-7877 South Carolina Usual Residence of Decedent 10a, Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits - show Nem 27 is marked other than "natural", or itema 23a or 28a-1 show other treumatic event, the Medical Examinar must be notified as 1 ☐ Yas 2 No Directo Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 990 Waterford Drive 21702 Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - Amarican Indian, 11. Marital Status Black, Whita, atc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specity: þ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mentel Hygien Important: If fem 27 is marked other the any filury or other treumatic event, the page. Self Homemaker 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) Napoleon Meetze Napoleon Alford Maude Bates 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Henry Meetze, son 2424 Stoney Creek Road, Frederick, MD 21701

ace of Disposition (Nama of Date 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematery, crematory or other place) 20a. Mathod ol Disposition 1 A Burial 2 Cremation 3 Removal Irom State 4 ☐ Donation 5 ☐ Other (Specify) Arlington National Cem. 6/28/2000 Arlington, Virginia 22. Nama and Address of Facility
Keeney and Basford Funeral Home 21 Signature of Funaral Service License M00999 106 East Church Street, Frederick, Maryland 21701 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart lailure. List only one cause on each line. **Physician** Immediata Causa (Final diseasa or condition resulting in death) /Medical Malnutrition 2 Mouth Examiner arcular physician and s the burial-trensit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or trijury that initiated events rasulting in death) Last P.O. Box 68760, Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yaa 2 No 3 Probably 4 Unknown signed t Records, by 24b. Wara autopsy findings available prior to 24a. Was an autopsy performed? Completed complation of causa of daath? 1 ☐ Yas 2 ☐ No Division of Vital 25. Was casa referred to medical examiner? Be 26. Place of Death (Check only ona) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidance 6 Dothar (Specify) ASSISTED 1 Yas 2 No I Director: After this code in by the funeral director Medical Certification: To 27. Manyer of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28d. Describe how injury occurred 28c. Injury at Work? To the Hospital or Attending i within 24 hours after death.

To the Funerel Director: After 5 Pending invastigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 ☐ Suicide Place of Injury - At homa, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Data signad (Month, Day, Year) 29c. License number 29b. Signature and titla of certifier 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Rose Count Frederick 4D Robert 1603 ocovher 31. Data filed (Month, Da 32. Regist State

DHMH 16 Ray 6/95

Registrar

2000

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Rea. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 12:40 p.m June 28 2000 BETTY ANN MYERS /Medical 4e Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2717 Milt Summers Road Middletown Frederick If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1□M 2√2F 67 Vrs **Director** 216-30-3798 Nov 4, 1932 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours aftar death with the Maryland Department of Health and Mentel Hygiene.

Timportant: If then 27 is marked other than "naturel", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☑ No Maryland Frederick Middletown Directo 10a. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2717 Milt Summers Road 21769 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates: Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Farmer Dairy Farm 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ernest Smith Mary Viola Bear 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles O. Myers/spouse 2717 Milt Summers Road, Middletown, MD 21769 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State tXXBurial 2 ☐ Cremation 3 ☐ Removal from State Mt.Zion U.Methodist Cemt. 6-30-00 Myersville, Maryland 4 Donetion 5 Other (Specify) 21. Signature of Funeral Service Li-22. Name end Address of Facility 504 Main Street Ricketts Funeral Home Myerville, MD 21773 ettle nplications that caused the death. Do not enter the mode of dylng, such as cardiac or respiratory errest, List only one cause on each line. Approximate Intervel Between Onset and Death Physician /Medical Immediate Ceuse (Finel 1221 -10 N diseese or condition resulting in death) Examiner Due to (or as a consequence of): Examiner physician end s the bunal-transit The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): P.O. Box 68760, Physician/Medical Due to (or es e consequence of). for use es signed by the eld be detached for Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ been sig 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy certificate has b lirector, page 2 s 1 Tyes 2 No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifica funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28e. Date of Injury (Month, Day Year) Certification: 27. Manner-of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 - Homicide .5 To the Hospital or within 24 hours eft To the Funeral Discompletely filled in 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and manner as stated.
2 Medical Examinar: On the basis of axi mination and/or investigation, in my opinion, death occurred at the time, date and placa, and due to the cause(s) end menner stated. 29a. Certifier Medical (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

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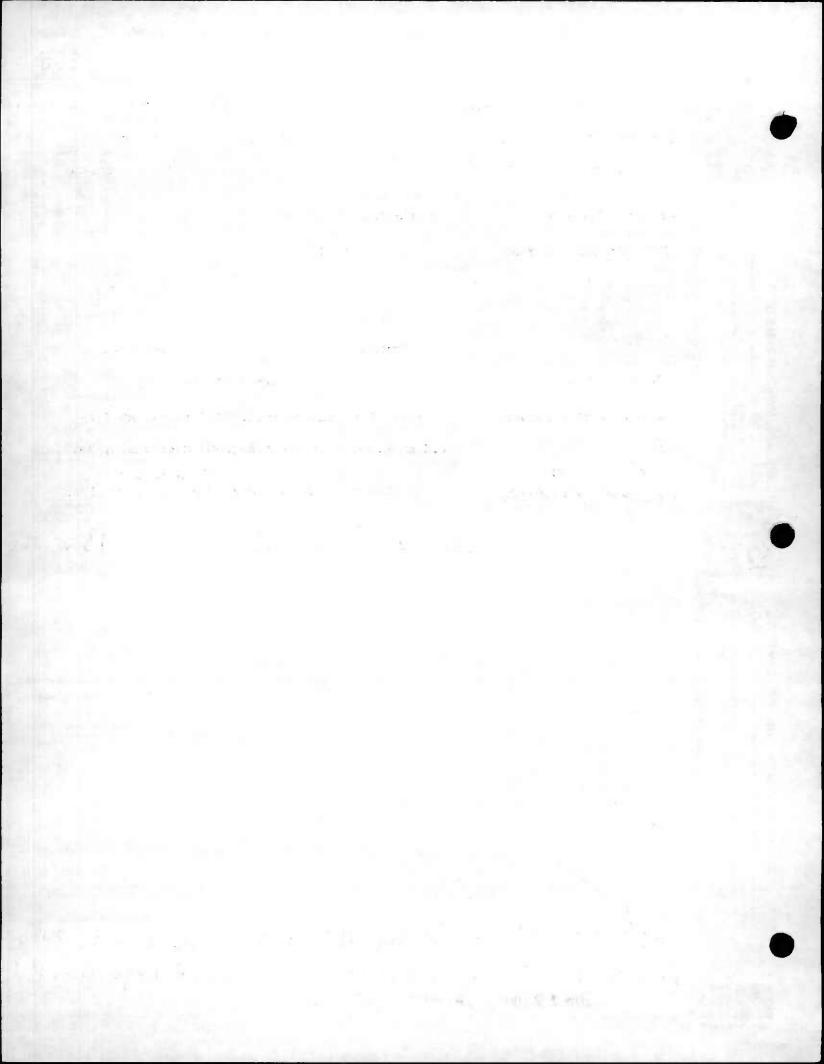
ampus Rd

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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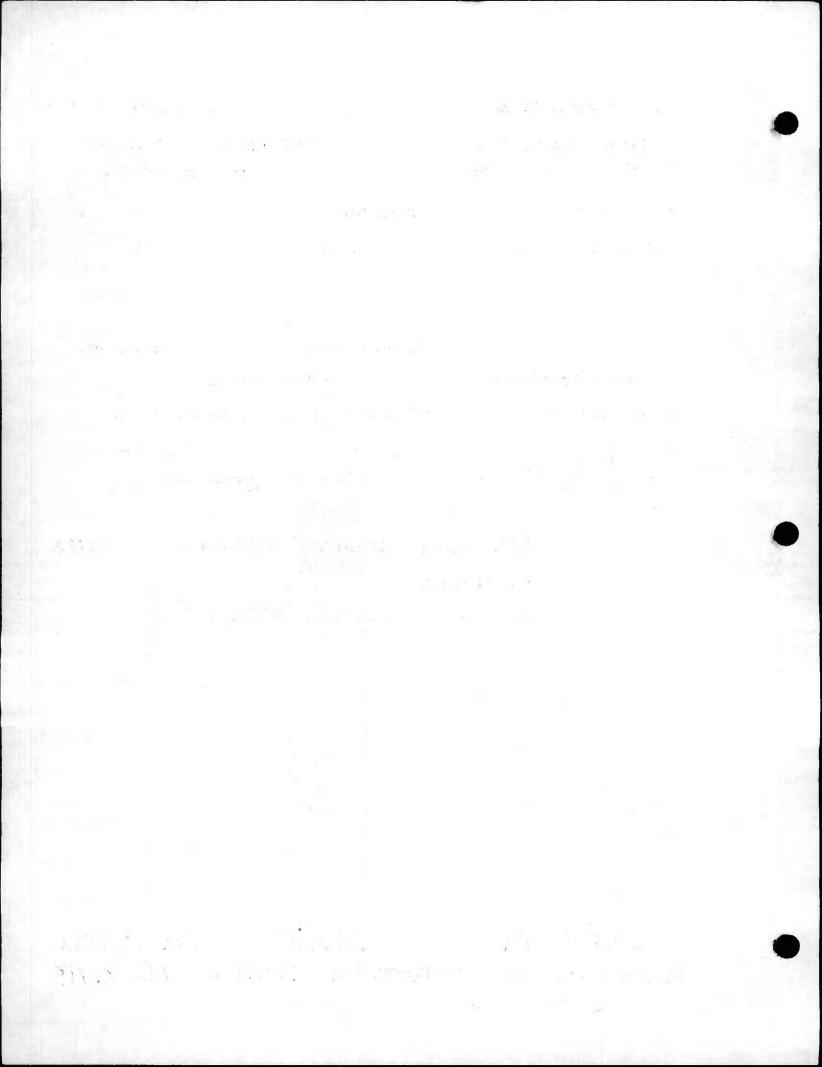
32. Registrents Signeture



State of Maryland / Department of Health and Mental Hygiene

				Certificate o	f Death		Reg. No.	0 2220	
lalan	1. Decedant's Nama (First, Mide	dia, Last)	2. Data of D Month	eath Day	3. Time of De				
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aminer	4a. Facility Nama (If not institution	on, giva street and number)			4b. City, Town,	or Location of Dea		y of Death	
	Williamsport	Nursing Home			Willia	msport	Was	hington	
eral	5. Social Security Number	6. Sex 7. Ag	a (In yrs. last birt	Months Day	er If Under 24 F	lin. (Month, E	irth Day, Year)	9. Birthplace (State or Fo	
ctor	180-10-6819 Usual Rasidence of Decedant	1 M 2 U 9	3	Yrs.		Sept.	21, 190	6 PA.	
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ō	MD. Wash	ington		Hagerstown	L			1 ☑ Yas 2[
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f Health and Mentel Hygiene. Item 27 is merked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at	17. Fethar's Name (First, Middla					Nema (First, Middl		na)	
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	19a. Informent's Name/Raletion Joanne F. Ryan		Rural Routa Num						
	20e. Method of Disposition	(INICCC)		8 Birch Kn Disposition (Nama of	OII Ru.,	Dete	_	- City or Town, Steta	
	1 Burial 2. □ ¢ramation		cemetar	y, crematory or othar p			47.60		
	4 Donation 5 Other (1/2	Lutne	ran Cemete		7/1	middlet	own, MD.	
	21. Signature of Funeral Sarvin	17/12	0	Donald B.	Thompso	n Funera	1 Home		
	() mayor	1 / WITH	2	31 E. Mai				21769	
	23a. Part I. Enter the diseasa, o	or complications that any sec st only one cause on the li	tha daath. Do n na.	ot antar the moda oi d	lying, such es cere	diec or respiratory	errast,	Approximata Intarval Betwee	
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/Medicai	rasulting in death) Last		Due to for as a c	onsequence ory.					
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by F						_	- 100		
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ple						-		completion of caus of death?	
Completed						1□	Yas 2 No	1 ☐ Yas 2 ☐ No	
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Certification:	3 Suicida 6 Could 4 Homicide datarr	not be nined 28e. Place of inju- building, atc	ury - At home, fer	m, straat, factory, offic	0		(Straat and Numi	ber or Rurel Routa Number,	
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	30. Nema and address of person who completed cause of death (Item 23a) (Type, Print)								
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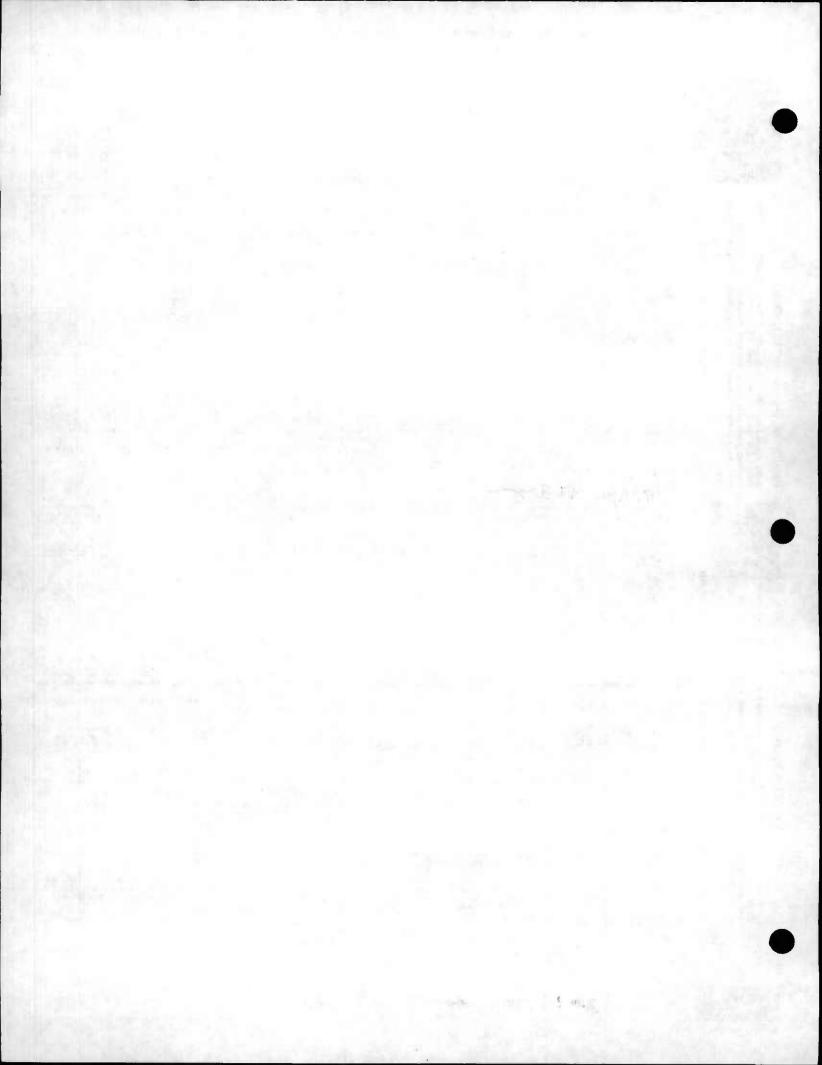
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State of Maryland / Department of Health and Mental Hygiene

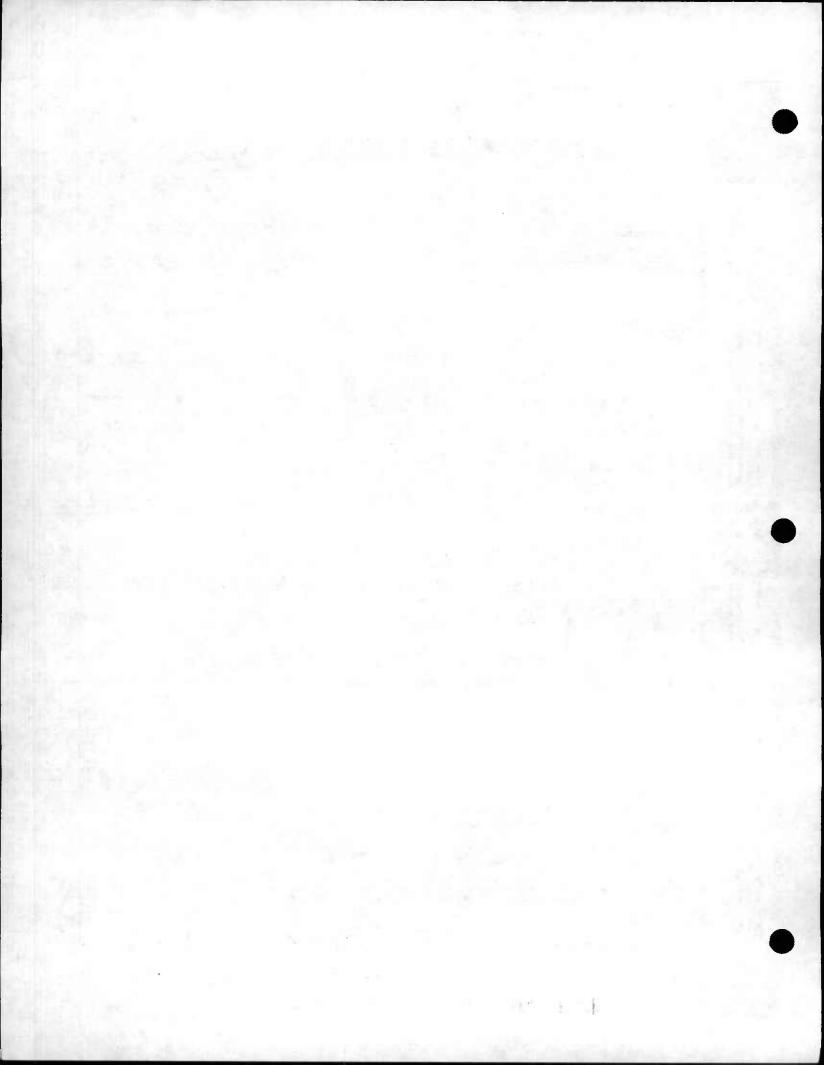
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Physician /Medical	Decedent's Name (First, Middle James	, (ast) Jewe	211	McE1				2. Dete of De Month June	27, 20	Year OO	3. Time of Dea 6:20 a	
Examiner	4a Facility Name (If not institution 35 West Freder:					lb. City, Too Walke		cation of Death		y of Death 'reder	rick	
Funeral Director	5. Social Security Number 170-12-7323 Usual Residence of Decedent	6. Sex 7. Ag 1 □ XM 2 □ F	ge (In yrs. last birth 78 Y	nday) If Under Months	1 Year Deys	If Under: Hours	24 Hrs. Min.	8. Date of Bir (Month, Da May 21	th ly, Year) , 1922	9. Birthp Cour Penn	plece (State or For http:) ISylvania	
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23a or 25a-fa ant be notified al Director	10e. Street and Number 35 West Frederi	ck Street		10f. Zip	Code 217	93			10g. Citizen of U.S		ntry?	
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nt: If Item 27 ry or other to	Mrs Ruth Nelson 20a. Method of Disposition 1 ⊠ Buriai 2 □ Cremation 4 □ Donation 5 □ Other (Sp	3 Removal from State	20b. Place of cemetery	West Find Disposition (Name of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of the composition of t	e of her plea	(0)		Date , 2000	20c. Location	- City or To	MD 21793 own, State Maryland	
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To the comp	29b. Signature and title of certifier	1	9	29c. License number 29d. Dete signed (Month, Day, 6/27/06								
State	30. Name and address of person of Richard L. Go. 31. Date filed (Month, Day Year)	ough, M.D.,		Frederi	ck S	treet	, Wa	ılkersv	ille, M	ary1a	nd 21793	



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State of Maryland / Department of Health and Mental Hygiene 22269 Certificate of Death 2. Dete of Deeth 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Dey Month **Physician** June 25, 2000 Howard M. Mainhart 9:30 a.m. /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner College View Center Frederick Frederick Birthplece (State or Foreign Country) If Under 1 Year 8. Date of Birth (Month, Dey, Year) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Hours Months Deys 1 MM 2□ F Director 214-14-6320 Dec. 19, 1917 Maryland Usuel Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 Yes 2 No Directo Maryland Frederick Frederick 10f. Zip Code 10g. Citizen of Whet Country? 10e. Street and Number Funerai 700 College Ave 21701 USA death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11 Merital Status permit. Peges 1 and 2 should be filed within 72 hours after of Depertment of Heelth and Mental Hygiene. Important: if item 27 is marked other than "natural", or item any injury or other traumatic evant, tra Medical Emmissions. 1 Never Merried 2 Married Saltimore. Maryland 21215-0020 1 Yes 2√No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondery (0-12) College (1-4or 5+) 4 mortgage broker real estate 18. Mother's Neme (First, Middle, Meiden Sumeme) 17. Father's Name (First, Middle, Last) Be 2 Lester Gravson Mainhart Rebecca Morsell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Melling Address (Streat end Number or Rurel Route Number, City or Town, Stete, Zip Code) Deborah Mainhart, daughter PO Box 337, Union Bridge, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriel 2 XCremetion 3 ☐ Removal from State Smithsburg Crematory 6/27/2000 Smithsburg, Maryland 4 Donation 5 ☐ Other (Specify) 21. Signeture of Funerel Service Licenses 22. Name and Address of Fecility Keeney and Basford Funeral Home 23a. Pert1. Enter the disease, or complications that claused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest,

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Interpretable to the disease, or complications that claused the deeth. 21701 Approximete Intervel Between Onset and Deeth **Physician** Immediate Cause (Final /Medical disease or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed Sequentielly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of) physicien s the buna Box 68760. Physician/Medicai Due to (or es e consequence of): 88 for use Part II. Other aignificant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown signed t by 24b. Were autopsy findings available prior to completion of ceuse of death? 24a. Wes an autopsy performed? Completed 1 ☐ Yes 2 No 1 Yes 2 No of Vital Physician: Be 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpetient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To this 27. Menner of Death 1 Neturel 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division To the Hospital or Attending 5 Pending investigation 1 Yes 2 No within 24 hours after deeth.

To the Funeral Director: A completely filled in by the fi deeth. 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29a. Certifier (Check only one) 29b. Signature and title of 29c. License number 29d, Dete signed (Month, Dev. Year) use of deeth (Item 23a) (Type, Print) emun 31. Dete filed (Month, Deg. State Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death Dev Yeer Month SON June 2000 222 am 4b. City. Town, or Location of Deeth 4c. County of Deeth

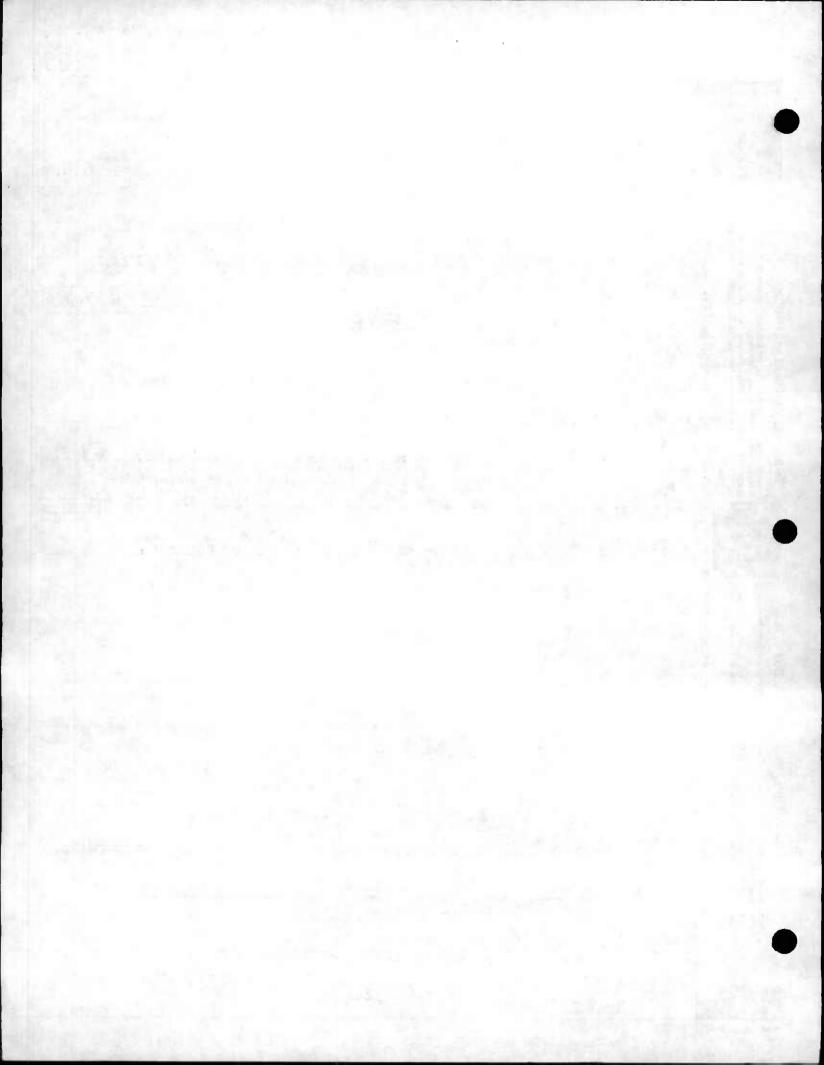
1. Decedent's Name (First, Middle, Last) **Physician** GIUIN /Medical 4a Fecility Name (If not institution, give street end number) Examiner Wicamico Salisbury Peninsula Regional Hospital 8. Dete of Birth (Month, Dey, Year) If Under 1 Year If Under 24 Hrs. 9. Birthplece (State or Foreign Country) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthdey) **Funeral** Deys Months Hours 10 M 20 F 216-56-M81
Usuel Residence of Decedent Yrs. Director with the Maryland 10d. Inside City Limits 10a. Stete 10h County 10c. City, Town or Location or items 23a or 28a-f show evant, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** 79770 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21864 permit. Pages 1 and 2 should be filed within 72 hours after death v. Experiment of Health and Mandal Hydrone.
Important: If farm 27 is marked other than "natural", or from 23a any Injury or other trauments are set. treo Ke 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Rece - American Indien, Black, White, etc. 11. Meritei Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Be Completed by 3 Widowed 4 Divorced lac 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) House Keeping 12+h NOrker Domertic 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Rollie Sr 01 501 mae Ohn la 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Reletionship (Type, Print) oke City, md, 2/81/ 20c. Location - City or Town, State Avonus 20b. Plece of Disposition (Name of cametery, cremetory or other plece) Ocomoka (Brother 10/500 1000 20e. Method of Disposition

1 Buriat 2 Cremetion 3 Removal from Stete Poconuko 4 Donetion 5 Other (Specify) Jeorge town ene fary 21. Signature of Funeral Service Licensee 22. Name end Address of Facily Bennic JMAL tuneral Home P.O. Box PoconoKa 331 flons that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Due to (or es e consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): The law requires that the death certificate be en physican s the burns Box 68760. Completed by Physician/Medical Due to (or es a consequence of) signed by the attending p 23b. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Pert II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 3 Probably 4 Unknown 1 Yss 2 No 24b. Were eutopsy findings eveileble prior to completion of cause of deeth? 24e. Was en eutopsy this certificata has 1 Yes Yes 2 No 2 No septal or Attanding Physician: Thours after death.
Ineral Director: After this certification filled in by the funeral director, pa 25. Was case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 XYes 2 □ No 2X ER/Outpatient 3 DOA 1 Inpatient 28d. Describe how injury occurred 27. Menner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28c. Injury at Work? 1 Naturel
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piece of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide Hospital 24 hours a To the Hospital within 24 hours a To the Funeral Completely filled 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es stated.

2 Medical Examiner: On the best of examinetion end/or investigation, in my opinion, death occurred et the time, date end plece, end due to the cause(s) end menner steted. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 29c. License number O.C.M.E. June 24, 2000 30. Name end address of person who completed cause death (item 23e) (Type, Print) 1 HOUDURE Penn Street, Baltimore, Maryland 21201 111 31. Dete filed (Month, Dey, Year) 32/Registrer's Signeture State

Registrar

JUN 2 7 2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 3. Time of Death 2. Dete of Death OWENS **Physician** MARTHA 9:30PM June 26, 2000 /Medical 4a Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** 6801 Bock Road #445 Prince George's Fort Washington If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 M 2 TF Yrs. 70 December 22, 1929N. Carolina Director 239 32 5391 Usual Residenca of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23s or 28s-4 show any Injury or other traumatic event, the Medical Exercites must be notified at once. 1 ¥ Yes 2 □ No Funeral Director Maryland Prince George's Fort Washington 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 6801 Bock Road #445 20744 Wes Decedent of Hispanic Origin? (Specify Yes or No-it Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Rece - American Indian, Bleck, White, etc. 1 Yes 2 No tt Yes, Give Year or Detes: 1 Never Merried 2 Married Specify: Black 1 Yes 2 X No Specify þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th Domestic Private Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Clarence Sumler Mary elizabeth Turner 19a. Intorment's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 2120 Alice Avenue #1 Oxon Hill, MD Cynthia Walters /daughter 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State Date 1 ₺ Burial 2 ☐ Cremation 3 ☐ Removel from State Glenwood Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 7 - 1Washington D.C. 22. Name and Address of Facilit MARSHALL S FUNERAL HOME OF MD re of Funeral Service License Susce force 4308 Suitland Road Suitland, MD 20746 23s Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart tellure. List only one cause on each line. **Physician** CORONARY ARTERY DISEASE /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner Examiner The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last P.O. Box 68760. Physician/Medicai Due to (or es e consequence ot): Pert it. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 thenknown of Vital Records, þ 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24a. Was en autopsy performed? Be Completed 1 Yes 2 No 1 ☐ Yes 2 ☐ No Physician: 25. Wes cese referred to medical 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Hesidence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 27. Manner of Death 28c. tnjury at Work? 28d. Describe how injury occurred Hospital or Attending Pl
 24 hours after death.
 Funeral Director: After th Division 5 Pending investigation 1 Neturel 1 Yes 2 No 2 Accident To the Hospital or Atter within 24 hours after der To the Funeral Directo completely filled in by the 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rurel Route Number, City or Town, State) 28e. Piece of Injury - At home, term, street, tactory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and piece, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) V. SINCH 7209 A HAPOVER PARKWAY GREENBELT MD 2:3710 31. Date filed (Month, Day, Year) 32. Registrer's Signeture

DHMH 16 Rev 6/95

Registrar

JUN 3 0 2000

No. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept. 18 Sept.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First Middle Last) 2 Data of Death JUNE Year **Physician** 5:31 A.M. 26,2000 Bethel D. Owens /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, give street end number) 4c. County of Death Examiner Baltimore City Mercy Hospital If Under 1 Yaer Hrs. 8. Data of Birth Min. (Month, Day, Year) Birthplace (Stata or Foreign Country) 5. Sociei Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Deys Hours 1 □ M 280 F Yrs. Director 040 05 4142 83 anuary 3, 1917 Connecticut Usuel Residence of Decedant show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examinar must be notified at NE Yas 2 No Director Maryland Howard Jessup 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20794 U.S.A. 8209 Cambridge Court Funeral 12. Was Decedent Evar in U,S.
Armed Forces?
1 ☐ Yas 2 ☑ No
If Yes, Give
Yeer or Detes: Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Maritel Status pemili. Pages 1 and 2 should be filed within 72 hours after a Department of Heelth and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Item any Injury or other treumetic event, the Herman Page. Bleck, Whita, atc. 1 ☐ Nevar Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: Specify: 3℃ Widowed 4 Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highast grada completed) (Giva kind of work done during most of working lifa. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) 12 Statistical Clerk U.S. Government 17. Fether's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Anna Colley Samuel Dillon 19a. Informant's Name/Raiationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) \$108 Sheffield Court Jessup Maryland 20784 Larry Owens 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stete 4 ☐ Donation /5 ☐ Other (Specify) 6/28/2000 Brentwood, Maryland Fort Lincoln Crematory 21. Signature of Funeral Sarvice Licensea 22. Nama and Addrass of Facility
Fort Lincoln funeral Home 3401 Bladensburg Road Brentwood Maryland 20722 23a. Fartt. Entar tha disease, or complications that caused the deeth. Do not entar tha mode of dying, such es cardiac or respiretory errest, shock, or haart failura. List only one ceuse on aech lina. Approximete tnterval Between Onset and Deeth **Physician** Immediata Causa (Final disaasa or condition rasulting in death) /Medical HEPATIC MONTH Examiner Examiner physicien and is the bunal-transit that the death certificate be executed Sequantially list conditions, if any, laading to immadiata causa. Enter Undarlying Cause (Disaase or injury that initiated avants rasulting in death) Last Due to (or as a consequance of) P.O. Box 68760, Physician/Medical Dua to (or as e consequence of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. been signed by t should be detach 1 Yes 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Wes an autopsy 1□ Yas ANO 1 ∏ Yas 2 ∏ No certificate or Attending Physician: 25. Wes casa rafarred to medical 26. Place of Deeth (Check only one) Other: 4 Nursing Homa 5 Rasidence 6 Other (Specify) Hospitel: 1 Inpatiant 2 EP/Outpatient 3 DOA 1 Yas 2 No Medical Certification: To 28c. Injury at Work? 27. Mannar of Death 28a. Date of injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred After 1 Natural 2 Accident 5 Pending n 24 hours aftar death.
he Funeral Director: After pletely filled in by the fun 1 Yas 2 No investigation 6 Could not be detarmined 3 Suicida 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Cartifiai To the Hosp within 24 ho To the Fune completely fi (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and titia of certifier 29c. License number William P. M. Since 4, 016801 06/26/00 30. Nama and addrass of person who complated causa of death (Item 23a) (Type, Print)

30. I St. PALE BALE

BAL BALTIMORE, MD 21202

Registrar DHMH 16 Rev 6/95

Records,

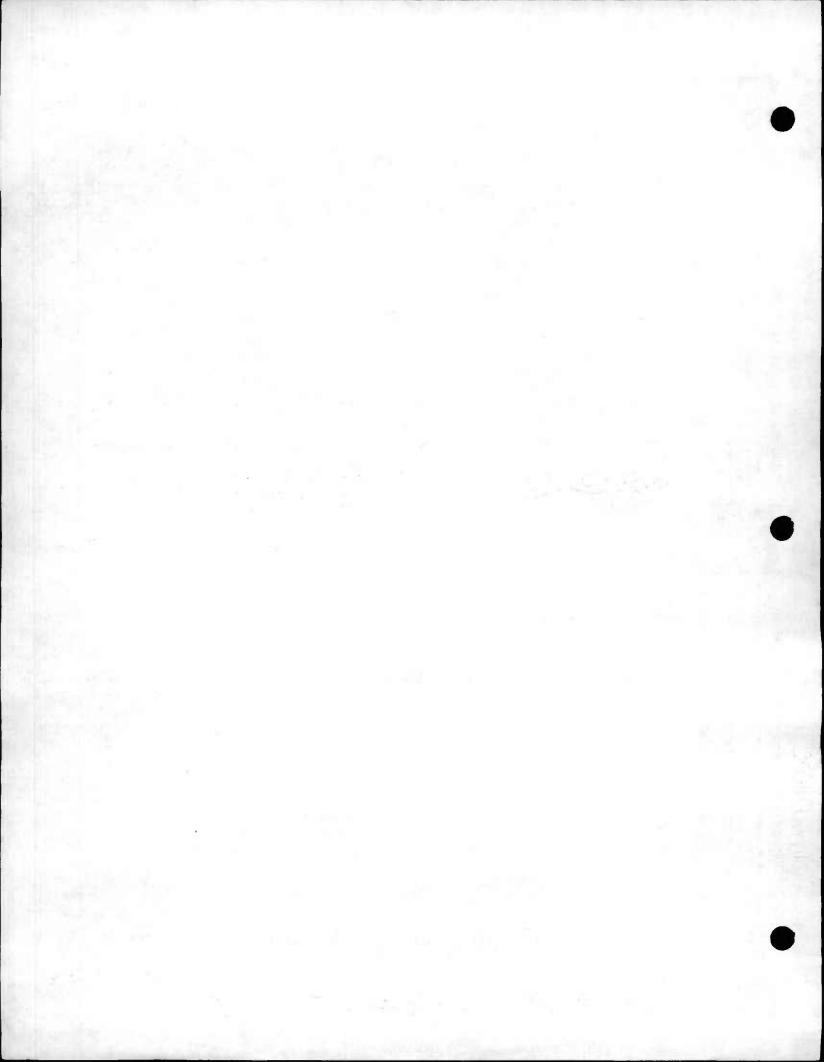
Division of Vital

2. Registrar's Signature

water We was 1000 8 S MUL

State of Maryland / Department of Health and Mental Hygiene amend item 20b,c, per fh G785 7/21/00 vg Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death **Physician** Allene Olmo 2000 1830 une 21 /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner Washington County Hospital Washington Hagerstown H Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Pay, Year) | 1945 5. Social Security Number 6. Sex Birthplece (Stete or Foreign Country)
 Michigan 7. Age (In yrs. last birthday) **Funeral** Months 1□M ACTF 54 Yrs. 430 80 7088 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits WV Morgan Berkeley Springs 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 105 Woodside Drive 238 25411 U.S.A. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Status parmit. Pages 1 and 2 should be flied within 72 hours after to Department of Health and Mental Hygiene. Important: if Item 27 is merked other than "natural", or her any injury or other traumatic event, the Medical Examiner 1 Never Married 2 Merried 1 ☐ Yes AND Specify: 3altimore, Maryland 21215-0020 White Specify: À 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Lab technician Printing 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Joseph Sebring Westnedge Allene Lane 19b. Meiting Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) Valerie C. Olmo 105 Woodside Drive, Berkeley Springs, WV 25411 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City or Town, Stete + Durial 2 ☑ Cremetion 3 ☐ Removel from State Greenwood Grove Cemetery 6/23/2000 4 ☐ Donetion 5 ☐ Other (Specify) mature of Funeral Service License 22. Name end Address of Facility Helsley-Johnson Funeral Home, Inc. M00522 306 Union St., Berkeley Springs, WV 25411-1837 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Non the fein's by my home Examiner Due to (or es a consequence of) Physician/Medical Examiner Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): of Vital Records, P.O. Box 68760, Due to (or as e consequence of): tate has been signed by the a page 2 should be detached to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobecco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings avellable prior to Be Completed 24a. Wes an autopsy performed? completion of cause of death? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Deeth (Check only one) Hospitel: 1 hpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how Injury occurred 28b. Time of 28c. Injury at Work? 1 Naturel 5 Pending investigation death. 1 Yes 2 No Hoepital or Attandi
 24 hours after death
 Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) filled in by 4 Homleide 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier To the Hosp within 24 hos To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 6.22:00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical Campus Rd. He sentown Michael McCornack 11110 31. Dete filed (Month, Day, Year) 32. Registrer's Signature State JUL 0 3 2000 Registrar



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Neme (First, Middle, Last) Month **Physician** June 28, Gino L. Piperni 2000 5:35 PM /Medical 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Fort Washington Hospital Prince Georges Ft. Washington If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number Birthpleca (State or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** Months Deys 1**X**) M 2□ F Yrs. Director 579-07-6317 79 Nov. 18, 1920 Italy Usuel Residence of Decedent Pages 1 and 2 should be filed within 72 hours efter death with the Meryland nemt of Heelth and Mentel hygiene.
Int: If them 27 is marked other than "natural", or items 23s or 28s-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits thm 27 is marked other than "natural", or flems 23s or 28s-f sho other traumatic event, the Medical Examiner must be notified at 1 Yes 2 No Prince Georges Temple Hills Maryland Directo 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 20748 USA 2010 Gaither Street Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White þ 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 8 Builder Building/Construction 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be Unknown Fabrizio Piperni Margharite 2 19e. informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 9800 Kisconko Rd., Ft. Wahington, MD 20744 Robert L. Piperni/Son 20b. Pleca of Disposition (Neme of cametery, cremetory or other plece) 20a. Method of Disposition Date 20c. Location - City or Town, Stete permit. Pages Department of H Important: If the any injury or of tOBurlat 2 ☐ Cremation 3 ☐ Removal from State S ☐ Other (Specify) 7/3/2000 Clinton, MD 4 Donation Resurrection Cemetery 22. Name and Address of Fecility George P. Kalas Funeral Home, P.A. 21. Signature also 6160 Oxon Hill Rd., Oxon Hill, MD 20745 23a. Pert1 Enter the disease, or complications this caused the deeth. Do not enter the mode of dying, such as cardlec or respiratory errest, shock, or heart feilure. List only one ceuse of each line. Approximete Intervel Between Onset end Deeth **Physician** Immediale Cause (Final disease or condition resulting in death) /Medical Examiner Examiner physician and the buriel-transit The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initieted events resulting In deeth) Lest Due to (or es e consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequenca of) attending p been signed by the a should be deteched t Part II. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert f. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 □ Unknown 1 Yes 2 No CORONARY ARTERY DISERSE þ 24b. Were eutopsy findings evelleble prior to completion of cause of death? Completed PARKINSON'S () IS EASE 24e. Wes en eutopsy performed? certificate has t director, page 2 s 1 ☐ Yes 2 ☐ No 1 Yes or Attending Physician: funeral director, Be 25. Wes case referred to medical exeminer? 26. Piece of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Nopatient 2 ER/Outpetient 3 DOA Certification: To this 28c. Injury et Work? 27. Menner of Deeth 28e. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of After 1 Neturel 5 Pending Investigation 1 Yes 2 No 2 Accident after deeth Director: 6 Could not be determined 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide filled In hours a 24 hours 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end pleca, end due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end plece, end due to the cause(s) end menner stated. 29a. Certifier Medical pletely (Check only one) To the To the To the F 29d. Dete signed (Manth, Dey, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of parson o completed cause of death (Item 23e) (Type, Print) Line Center Waldorf, Md 20602 12070 31. Date filed (Month, Day, Year) 32. Registrer's Signature State JUN 3 0 2000 Registrar

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 12. Data of Death

		State of Marylan		icate of			Reg. No.	00	22276	
Physician /Medical	outlier rice borre			2. Data of Dea Month O	Death 3. Time of Death 21 2000 2:07 pm					
Examiner	An English Atoms - Manager to the state of the				Lanham	ocation of Death	4c. County			
Funeral Director	370-40-0003	7. Age (<i>in yr</i> s.		Under 1 Year onths Deys	If Under 24 Hrs. Hours Min.	8. Data of Bird (Month, Da 3-3-2	irth (9. Bit (23) (Cli		inthplaca (Stata or Foreign Country), ffside, NC	
Maryland -1 show	Usual Residence of Decedant 10a. Stata 10b. County MD P.G.		y, Town or Location	on					d. Insida City Limits 1 Yas 2 No	
with the Ma 3a or 28e-f s the notives 3i Director	10e. Street and Number 9166 Springhill L	0f. Zip Code 20710	0		10g. Citizen of What Country? United States					
within 72 hours after death with the Maryland ene. Than "natural", or ferme 23a or 28e-f show the Medical Examinar must be notified at ampleted by Funeral Director.	3 Widowed 4 □ Divorced	12. Was Decedent Evar in U, Armed Forces? 1 ☐ Yas 2☑ No If Yas, Giva Yaar or Datas:	med Forces? If Yas, specify Cult] Yas 2X No /as, Giva 1 ☐ Yas 2X No			ecify Yas or No Rican, etc.)	No- 14. Race - American Indian, Bleck, White, etc. Specify: Black			
10 To 10 10 10	(Specify only highast grade	15. Decedent's Education (Specify only highest grade complated) 1 Z GLade College (1-4or 5+)				ing	16b. Kind of Business/Industry Georgetown Hospital			
should be filed and Mental Hygis marked other umatic event, I	17. Fathar's Nama (First, Middla, Last) Benjamin Mercer	School School	405 34585- 4	11	18. Mother's Nama (First, Middla, Maiden Surnama) Isabella McElrath t and Number or Rural Routa Number, City or Town, Stete, Zip Coda)					
1 and 2 sho Health and em 27 is m other traum	19a. Informant's Name/Reletionship (Ty Carolyn Lewis — Da	ughter	9166 Sp	ringhi	11 Lane		elt, Md	20710)	
nit. Pages 1 and bartment of Haalth ortant: If Item 27 Injury or other to	20a. Method of Disposition 1 Aburial 2 Cremation 3 R 4 Donation 5 Other (Specify)	ry 6/	Data 27/00	20c. Location - Cheltenl						
permit. Pa Departmen Important: any injury ance.	21. Signature of Funaral Sarvice License 23a. Part 1. Enter the disease, or complishock, or heert failure. List only or	my M01178	420	H Str	ss of Facility Y Funeral et, NE ng, such as cardiac	Washing	ton, DC		Approximate	
Physician /Medical Examiner	Immediata Causa (Final disaesa or condition rasulting in death)							, ,	Cucy.	
eeth certificate be executed attending physician and I for use as the bunial-transit clary/Medical Examiner	Causa (Disaasa or injury that initiated avents rasulting in death) Last	Dua to (o	r as a consequand	ce of):	e He	esx (- a xu	6	6 mgs.	
at the death cert d by the attending stached for use PhysiciaryM	Part II. Other significant conditions con	Part II. Other significant conditions contributing to death but not resulting in the underlying cause give						co use contributa to the cause of death?		
5 50 -	00							1 Yes 2 1 10 3 Probable 24e. Was an autopsy performed? 24b. Wara availate		
I or Attending Physician: The law requires after death. Shector: After this certificate has been signs in by the funeral director, page 2 should be entification: To Be Completed by						10	ras 2 No	of de	plation of causa seth? Yas 2 No	
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To the comple	29b. Signature and title of certifier	into our)	29c. Licens	a number	2	29d. Data signed	d (Month, De	ay, Year)	
(5)	30. Nama and address of person who co	mplated causa of death (Itam	123a) (Type, Print		way Re	d Gi	eenbe	HW	D 2017	

State Registrar

DHMH 16 Rev 6/95

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 2000 June 20, Warren Clayton Perry, Sr. 6:50AM 4b. City, Town, or Location of Death 4a Fecility Neme (If not institution, give street and number) 4c. County of Death Takoma Park Washington Adventist Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last Montgomery If Under 1 Yeer If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplece (Stete or Foreign Country) 8. Date of Birth (Month, Day, Year) Days Months Hours XXM 2□ F 63 Yrs 579-46-9548 Usuel Residence of Decedent Oct. 4,1936 Washington DC 10b. County 10c. City, Town or Location 10d. Inside City Limits Hvattsville Maryland Prince George's 1 ☐ Yes 2 ☑ No 10e. Street and Number 10f. Zio Code 10g. Citizen of Whet Country? 7105 Glenridge Drive 20784 U.S.A. 14. Race - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Stetus 1 TYes 2 □ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 ☐ Yes 2 ☐ No Specify: Specify: 3.☐.Widowed 4 □ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry N/A College (1-4or 5+) Elementery/Secondary (0-12) Nursing Assistant Federal Government 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) John Edward Perry Dorothy Pauline Brown 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Warren Clayton Perry, Jr. (Son) 7105 Glenridge Drive Hyattsville, MD 20784 20e. Method of Disposition 20b. Place of Disposition (Name of cametery, cremetory or other place) Lee Crematory Dete 20c. Location - City or Town, Stete 1 ☐ Buriel 2 Cremetion 3 ☐ Removel from Stete June 22, Clinton, Maryland 4 ☐ Donelion 5 ☐ Other (Specify) 21. Signature of Fuheral Se 22. Name end Address of Fecility Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Intervet Between Onset end Deeth Immediete Ceuse (Finel diseese or condition resulting in deeth) nouman Due to (or as a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Lest Due to (or as e consequence of): Due to (or es e consequence of) Pert il. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were eutopsy findings available prior to completion of cause ot death? 24e. Wes en autopsy N/A 1 ☐ Yes 2 Mo 1 🗆 Yes 25. Wes case referred to medical examiner? 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Xinpatient 2 ☐ ER/Outpatient 3 ☐ DOA

Physician /Medical **Examiner**

Physician

/Medical

Examiner

Funeral

Director

28a-f show

Director

Funeral

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Completed

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2

r than "natural", or itema 23a or 28a-f show the Medical Examinar must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after death w Department of Health end Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itama 23a and Injury or other traumatic avent, the Medical Exemplant research 2006.

Baltimore, Maryland 21215-0020

with the Maryland

The law requires that the deeth certificate be executed

P.O. Box 68760.

Records,

Division of Vital

Hospital or Attanding Physician:

deeth.

after deeth

burial-tran signed by the a Medical Certification: To filled in by the

certificate

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After

Physician/Medical Examiner þ Be Completed

27. Menner of Death

24 hours completely To the Within 2 To the

31. Dete filed (Month, Dey, Year) State JUN 2 7 2000 Registrar

1 Netural

2 Accident

4 Homicide

(Check only one)

3 Suicide

29a, Certifier

28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify)

28b. Time of

29c. License number D45660

28c. Injury et Work?

1 Yes 2 No

15 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end place, and due to the cause(s) end menner stated. 29d. Date signed (Month, Dey, Year)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

28d. Describe how injury occurred

of person who completed cause of deeth (Item 23e) (Type, Print) D. Singhy M.D. 30. Neme and eddress -ex

5 Pending investigation

6 Could not be determined

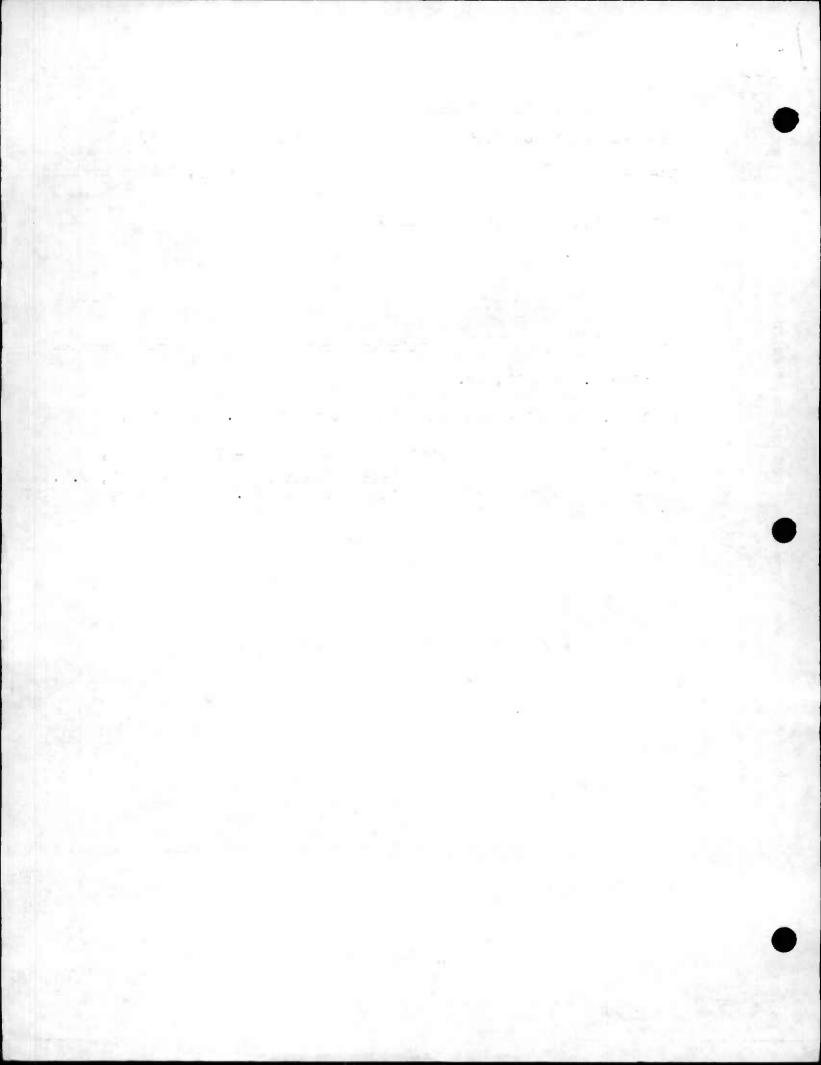
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28a. Dete of Injury (Month, Dey Year)

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29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(and menner stated). 29b. Signeture end title of eartifier 29c. Licensa number 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed ceuse of deeth (Item 23e) (Type, Print)	erille		3 Suicide 6 Could not be determined 28e. Plece of Injury - At home, ferm, street, fectory, office									ber or Run	al Route f	lumber,		
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DHMH 16 Rev 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Neme (First, Middla, Last) 2 Date of Death 3. Time of Death Month Day Year Year 30,2000 **Physician** 1205 g.m Lucille nmn PALMER /Medical 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Avalon Manor Health Care Center Hagerstown Washington If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth 5. Social Security Number 6. Sax 7. Aga (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Months 1 M 2 F Yrs. Director 219-44-2893 78 March 2, 1922 Maryland Usual Rasidanca of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or flams 23s or 28s-f show the Medical Examiner must be nothled at 1 ☐ Yas 2 No Director Maryland Washington Hagerstown 10e. Street and Number 10g. Citizen of Whet Country? 123 Plantation Drive 21740 Funeral U.S.A. 12. Was Decedant Evar in U,S.
Armed Forcas?

1 Yas 2 No Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, atc. 11. Marital Status 1 Nevar Married 2 Married 21215-0020 Yas. Giva 1 ☐ Yes 2 ☐ No Specify: Specify: 3 □XWidowed 4 □ Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grade completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filed w Department of Health and Mental Hygien Important: if item 27 is marked other th any Injury or other traumatic avent, the 8 0 Seamstress Clothing Manufacturer Baltimore, Maryland 17, Fathar's Nama (First, Middla, Last) 18. Mothar's Nema (First, Middle, Maiden Sumama) Be Custantino Brown Essie Huff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Donald Shumaker -Son-In-Law 101 Kerns Drive Boonsboro, Maryland 21713 20b. Plece of Disposition (Nama of cematery, cremetory or other place) 20e. Mathod of Disposition 1

Burial 2 □ Cremation 3 □ Ramovat from State 4 ☐ Donation 5 ☐ Othar (Specify) Greenlawn Memorial Park 7/3/00 Williamsport, Md. 21. Signature of Funeral Sarvice Licensee 22 Nama and Address of Facility Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740 23a. Part 1. Entar the disease, or complications the similar of the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediata Cause (Final disaasa or condition rasulting in daath) /Medical Rend End Steg D'ream Examiner Dua to (or as a consequence of): Examiner malheters Ty Diahr The law requires that the death certificate be executed Sequantielly list conditions, if any, leading to immadiata causa. Entar Undarlying Cause (Diseasa or injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): 68760 Physician/Medical the Due to (or as a consequence of): P.O. Box Part II. Other algnificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Arley sinon Anterio acterdic 1 Yes 2 No 3 Probably 4 Unknown Records. þ Deren Hopertine Charic 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Pulmoney Diren Varance Dinen 1 Yas 2 No 1 ☐ Yes 2 ☐ No of Vital Attending Physician: 25. Was casa rafarrad to medical examiner? Be 26. Placa of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Norsing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Division 1 Natural 5 Pending death. 1 Yes 2 No invastigation 2 Accident 24 hours efter deal Funeral Director: 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida 6 Hospital Medical 29a. Certifian 1/1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end menner as stated. (Check only 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end pleca, and due to the cause(s) and manner stated. within 2 To the \$ 29b. Signatura and titla of certifiar 29c. License number 29d. Data signed (Month, Day, Year) -conting P1081 Q JUNE 30, 2003

Registrar

State

Street, Hagerstown, MD 21740

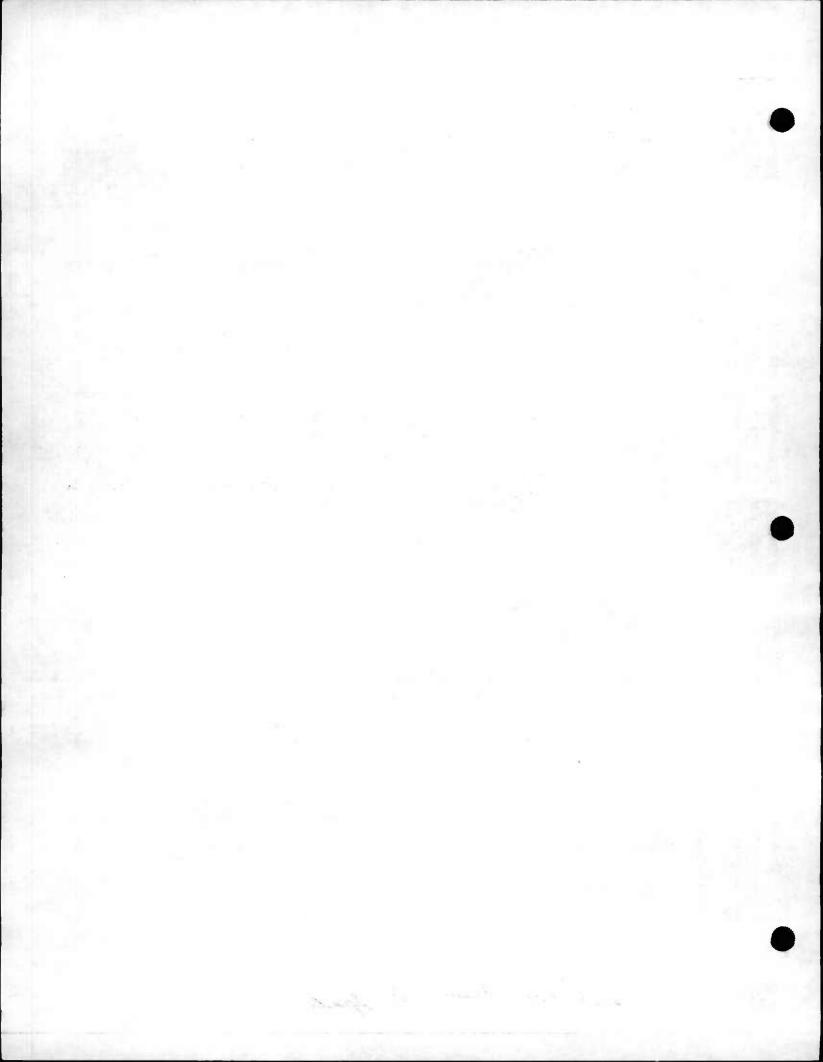
30. Nama and addrass of person who completed causa of death (Itam 23a) (Type, Print)

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31. Data filed (Month Day, Year) 2000

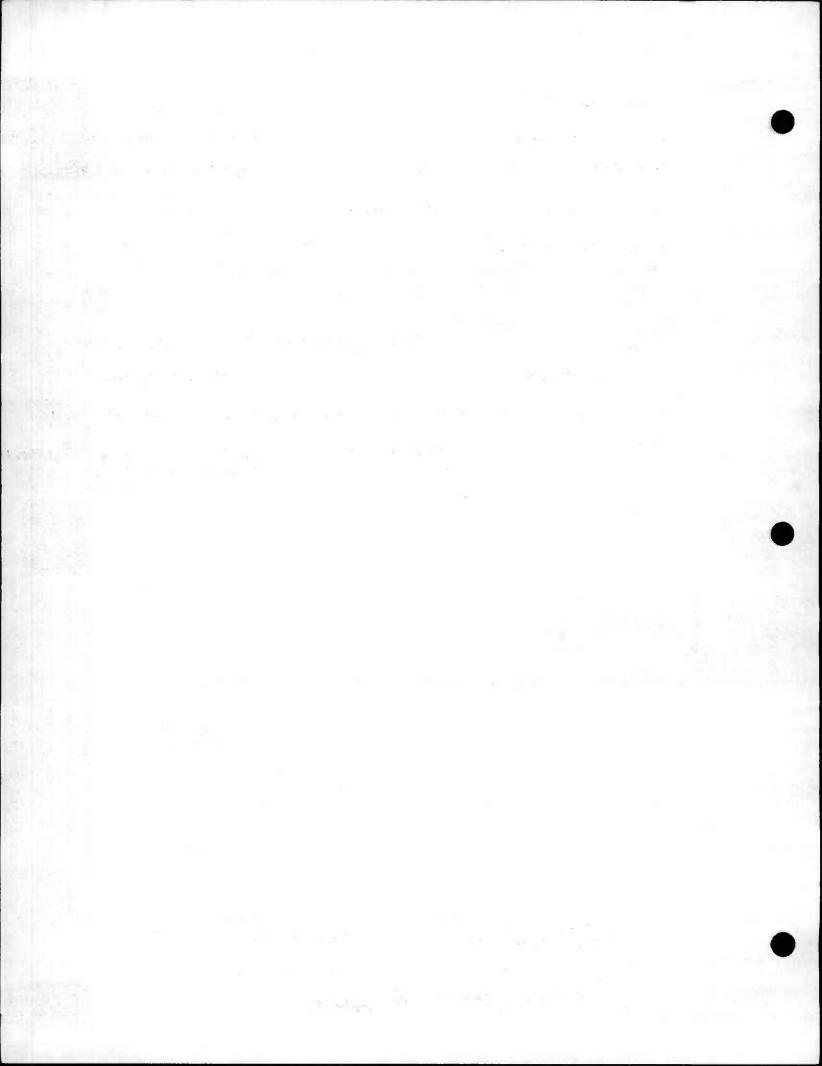
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32. Ragistrar's Signatura



State of Maryland / Department of Health and Mental Hygiene 00 2228

					Cert	tificate	of of	Death		R	eg. No.		
Physic		1. Decedant's Nama <i>(First, Middla, L</i> Hazel Marie					2. Data of Death Month Day Year 6 30 200			3. Time of Death			
/Medi Examii		4a. Fecility Nama (If not institution, g Homewood Retir								ocation of Deeth	4c. County		
Funeral Director		233-34-3530	Sax 1□M 2☑F	7. Aga (In yrs. last b		If Under 1 Months	1 Year Days	If Under Hours	Min.	8. Data of Birth (Month, Day April 2	Year)	9. Birthpl Count	aca <i>(State or Fore</i> try) Virgini
Meryland H show	tor	Usual Rasidance of Decedant 10a. Stata 10b. County Maryland Washin	gton	10c. City, Tov		ation sport						10	od. Inside City Lim
h with the 3a or 28a at be not	al Director	10e. Street and Number 16613 Tammany M.	anor Roa	d		10f. Zip (795		10g. Citizan of What Country? U.S.A.			ry?
permit. Peges 1 and 2 should be liled within 72 hours effer death with the Meryland Department of Heelth and Mental Hygiene. Department of Heelth and Mental Hygiene. Infraportant: If them 27 is marked other than "natural", or itema 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be purified at ance.	by Funeral	11. Marital Status 1 □ Nevar Married 2 ☒ Married 3 □ Widowed 4 □ Divorced	Armed For	2⊠No liva 1□Yas 2⊠No Specify:			ecify Yas or No- Ricen, atc.) 14. Rece - An Black, Wh Specify: W			itc.			
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iding physician and ise as the buriel-transit	/Medical Examiner	Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	c	Due to (or as a	2.7.11-								
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De de	Be Con	25. Was cesa refarred to medical						28 Place	of Death	1 🗆 Y		1□	Yes 2□ No
within 24 hours efter death. To the Funeral Director: After this certificate he completely filled in by the funeral director, pege	P	axaminar? 1 Yas 2 No 27. Mannar of Death 1 Natural 5 Panding 2 Accident invastigati	28a. Data o (Monti		utpatient Time of Injury	3□ DO#	c. Injur	ner: 42/Nu	rsing Ho	ma 5 ☐ Raside 28d. Dascribe h	ance 6 Oth)
urs efter dez ral Director lied in by th	Certification:	3 Suicide 4 Homicide 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 28f. Location (Streat and Number or Rural Route No. City or Town, State)											
iin 24 hot the Funei ipletely fil	edical	29a. Cartifiar 1 ☐ Certifying P (Check only one) 2 ☐ Medical Exa	hystcian: To the iminar: On the ba and mann	best of my knowledg sis of axamination ar ar stated.	e, daath o nd/or Inva	occurred at estigation, i	t tha tir in my o	ma, data an pinion, daa	d place, a	and dua to tha c ed at tha tima, d	ausa(s) and ma ata and place,	innar as str and dua to	ited. tha causa(s)
with To 1	×	29b. Signature and titla of certifiar	Kugler 1	mo		29c.	Licens	e number	579	ad at the time, d	9d. Date signed		lay, Year)
		30. Nama and addrass of person who R. L. Kusler, M		of death (Itam 23a) Northe	(Type, P	rint)	He	gentan	-, M	2 217	42		
Sta Registr		31. Data filed (Month, Day, Year) JUL 0 3 2	000 32. Re	distrar's Signatura	B.	do	Pi.	6					



State of Maryland / Department of Health and Mental Hygiene 22282 Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Physician July 2000 7:30 a.m. Thomas Leroy Pompell /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Neme (If not institution, give street end number) Examiner Hagerstown Washington 12313 Learning Lane H Under 1 Year | H Under 24 Hrs. | 8. Dete of Birth | 9. Birthplece (State or Fore Months | Deys | Hours | Min. | Feb. 14, 1943 | Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthpiece (State or Foreign **Funeral** 1 M 2□ F 56 213-42-1646 Yrs Director Usuel Residence of Decedent 10c. City, Town or Location 10a. Stete 10b. County 10d. tnside City Limits or 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or thems 23a or 28a-f ahow any fujury or other traumatic event, the Medical Empires must be notified at answ 1 Yes 2 No Director MD Hagerstown Washington 10e. Street and Number 10g. Citizen of Whet Country? 10f. Zip Code 12313 Learning Lane 21740 S. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American indien, Bleck, White, etc. 11. Meritei Stetus 1 ☐ Yes 2 ☑ No If Yes, Give △ Yeer or Detes: 1 Never Married 2 Married White Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Self employed Elementery/Secondary (0-12) Coilege (1-4or 5+) Carpet Mechanic Private Business 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 2 Rosalie Welty Charles Pompell 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Hagerstown, MD 21740 Mrs. Donna L. Pompell / spouse 12313 Learning Lane 20b. Plece of Disposition (Name of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20e. Method of Disposition Date N Burlel 2 ☐ Cremetion 3 ☐ Removal from Stete Rest Haven Cemetery 1/5/00 Hagerstown, MD 4 ☐ Donetion 5 ☐ Other (Specify) 22. Name end Address of Fecility Rest Haven Funeral Chapel 21. Signeture of Funeral Service Licansee 1601 Pennsylvania Ave. Hagerstown, MD 21742 or or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, that only one cause of reach line. Approximete Intervel Between Onset end Deeth **Physician** /Medical Immediete Ceuse (Finel 49 YS diseese or condition resulting in death) Examiner Due to (or es e consequence of): Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury and Due to (or es e consequenca of): Division of Vital Records, P.O. Box 68760, that initieted events resulting in death) Lest Due to (or es e consequence of) the USB AS 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown amua 200 þ 8 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Wes en eutopsy 1□ Yes 2□No 1 ☐ Yas 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after death.

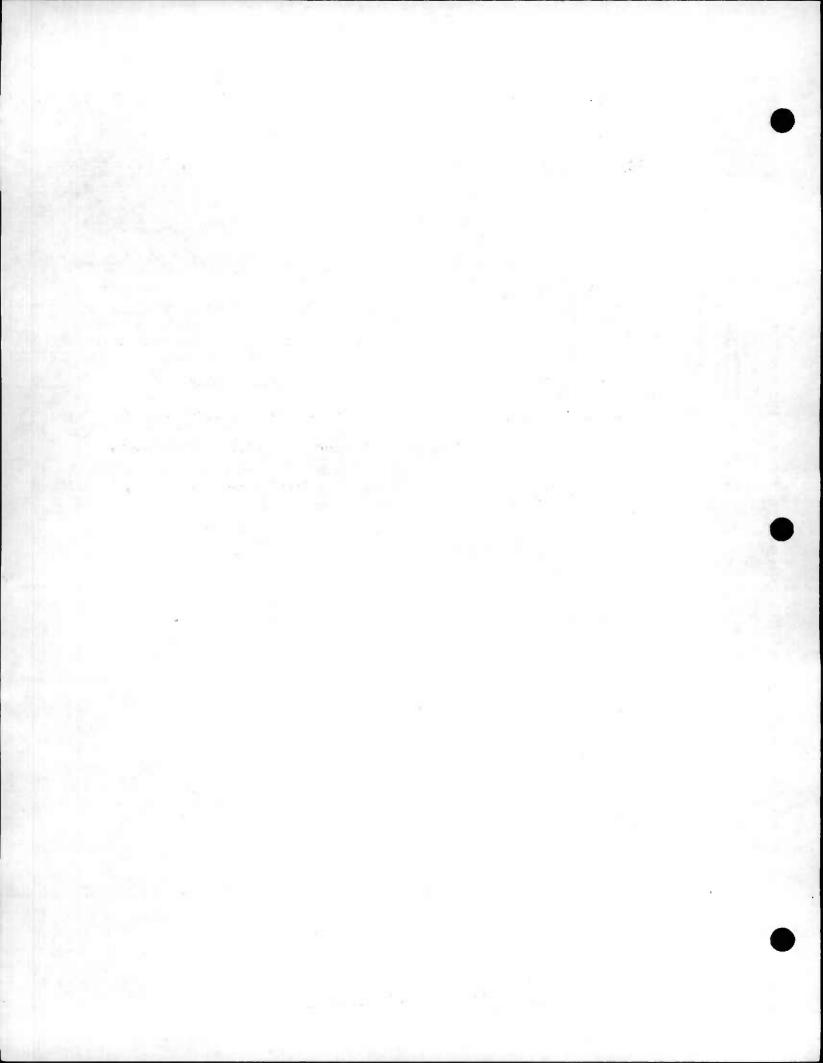
To the Funeral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medicat Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 1 Neturet 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 3 Suicide 281. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Pieca of injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the cause(s) and menner es stated.
2 Medical Examiner: On the basts of examinetion end/or investigation, in my opinion, deeth occurred et the time, date end place, end due to the cause(s) and menner stated. edical 29e. Certifier (Check only one) 29b. Signeture and title of ce 29d. Date signed (Month, Dey, Year) 29c. License number of death (Item 23a) (Type, Print) Cu Ches 84 31. Date filed (Month, Dey, Year) 32. Registrar's Signeture State

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Registrar

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year **Physician** Alice m. Papazian

4a Facility Name (If not institution, give street and number) Month July 5:30 A.M 5 2000 /Medical 4c. County of Death 4b. City. Town, or Location of Death Examiner Rancho Washington 20731 Boonsboro If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 9, 1926 5. Social Security Number 7. Age (In yrs. last birthday) Birtholace (State or Foreign Country) 6. Sex **Funeral** 1 M XXF Belgium 73 Yrs. 116-38-6522 Director Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Md. Prince George's College Park 1 Yes 2 No Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 8 6 6200 Westchester Park Dr. Apt. 917 20740 U.S.A r than "natural", or items 23a Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 11. Merital Status filed within 72 hours after 1 Never Merried 2 Married 21215-0020 1 Yes ANO Specify: White f Yes, Give Year or Dates: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home. tem 27 is marked other other traumatic avant, Baltimore, Maryland permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any Injury or other traumatic avent, 2028. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Armenag Hovaghimian Archelous Tcherkezian 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Artin H. Papazian (Husband) 6200 Westchester Park Dr. Apt. 917 College Park. Md. 20b. Place of Disposition (Name of cometery, crematory or other place)
Smithsburg Crematory July 6,2000 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Smithsburg, Md. 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility 12525 Bradbury Ave. Davis Funeral Home Smithsburg, Md. 21783 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** immediate Ceuse (Finel disease or condition resulting in death) /Medical Metastatic breast cancer year Examiner Due to (or es e consequence of) Physician/Medicai Examiner The law requires that the death certificate be executed burial-tran Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. Due to (or as a consequence of) for use as the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ð page 2 should be 24b. Were autopsy tindings evailable prior to completion of cause of death? Completed 24a. Was an autopsy 1 Yes 2 No t ☐ Yes 2 ☐ No certificate Division of Vital or Attanding Physician: funeral director, 25. Waa case referred to medical Be 26. Place of Death (Check only one) daughters Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1□ Yes 2 No Other: 4 Nursing Home 5 Residence 6 (Pother (Specify) Medical Certification: To After this Home 28a. Date of Injury (Month, Day Year) 27. Manufer of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 5 Pending investigation 1 Natural 1 TYes 2 □ No death. 2 Accident after deatl Director: 6 ☐ Could not be determined 28e. Place of Injury - At home, tarm, street, factory, office building, etc. (Specify) To the Hospital or Atta within 24 hours after de To the Funeral Director completely filled in by th 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homleide 29a. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7.5.00 mulowal MO. D 41667 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) 11110 Medical Campus Rd. Hagerstown, MD 21742 J. Mc Cormack Michael 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 5 2000 Registrar

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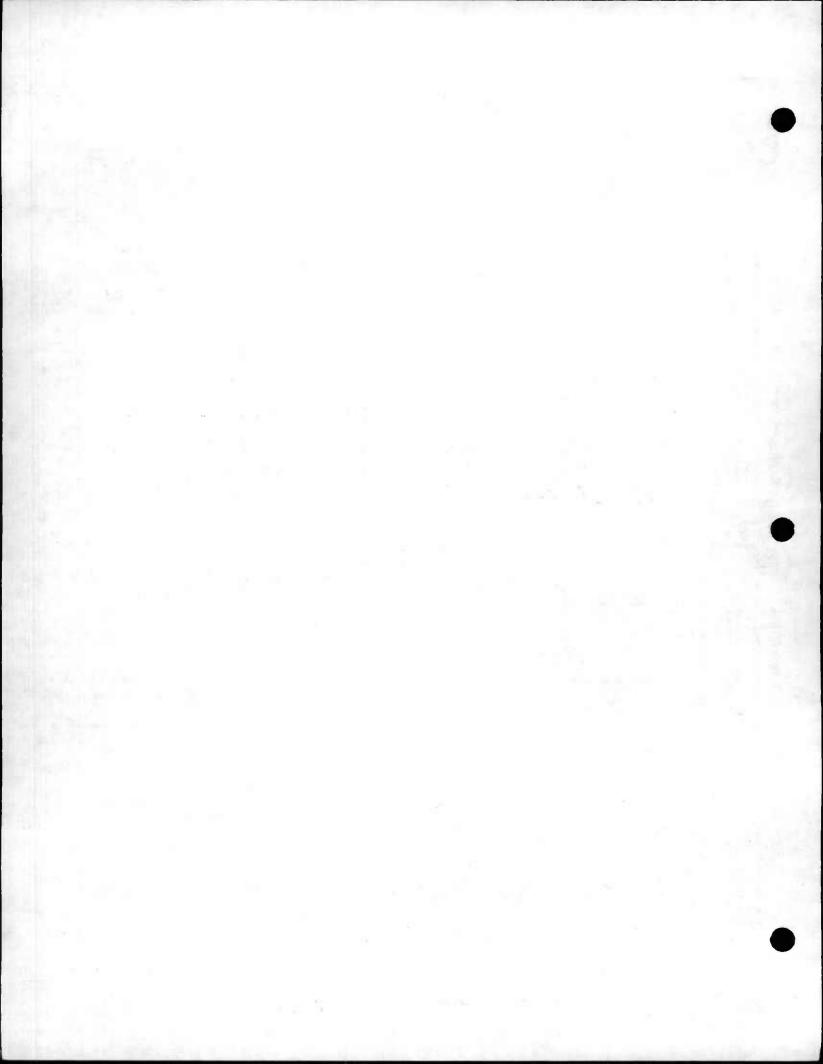
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Tima of Death Putman Month Year :5 A **Physician** ichael Alton 27 2006 June /Medical 4s Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Frederick Memorial Hospital Frederick Frederick If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Aug. 21, 1950 If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Yes 49 Director 213-76-5074 Maryland Usual Residence of Decedent pernit. Peges 1 and 2 should be filled within 72 hours efter death with the Meryland Department of Heelth and Mentel Hyglena. Important: if item 27 is merked other than "natural", or items 23a or 28a-f show with fulury or other treumsite event, the Medical Exemples must be notified at 1008. 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 No Director Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2202 Waller House Court 21702 U.S.A. 12. Was Decedent Ever in U,S. Armed Forcas? 1 ☐ Yas 2 ☐ No If Yas, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian. Black, Whita, atc. 1 Never Married 2 Married Saltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Plumber Plumbing & Heating 18. Mother's Nama (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) Alton Roy Putman June Snyder 19a. Informant's Name/Ratationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 2202 Waller House Court, Frederick, MD 21702 Diana Putman (Wife) 20b. Place of Disposition (Nama of cemetary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cremation 3 □ Removal from Stata Mount Olivet Cemetery 6/30/00 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 21. Signature of Funeral Service Licent 1201 NORTH MARKET ST., FREDERICK, MD 21701 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Approximata Interval Batween Onset and Death **Physician** CARDIAL ARREST Immediata Causa (Final disease or condition resulting in death) /Medical immediate Examiner Examiner ARTERIOSCLENOTIC CARDIOVASCUCAR 1 year ettanding physician and for use as the burial-transit The law requires that the deeth cartificate be executed DISCAST Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to (or as a consequence of): P.O. Box 68760, Physician/Medical Dua to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, p 24b. Wara autopsy tindings available prior to 24a. Was an autopsy performed? Completed complation of cause of daath? 1 ☐ Yas 2 No 1 ☐ Yas 2 ☐ No To the Hospital or Attanding Physician: within 24 hours effer daeth.

To the Funeral Director: Affer this certifica completely filled in by the funeral director; I 25. Was casa refarred to medical axaminer?

1 Yas 2 No B 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Deta of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 28b. Tima of 5 Pending invastigation 1 Natural 2 Accident 1 Yes 2 No 6 Could not be 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To tha best of my knowledge, death occurred at the tima, data and place, and dua to tha cause(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and mannar stated. edical 29a. Certifier (Check only one) 29b. Signature and July of certifier 29c. License number 29d. Data signed (Month, Day, Year) lano June 29, 2000 MD 00022037 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) BRUNSWICK, MA LINCAND NINTM AUC 600 31. Data filed (Month, Day, Year) 32. Registra Signatura State JUN 3 0 2000 > Registrar

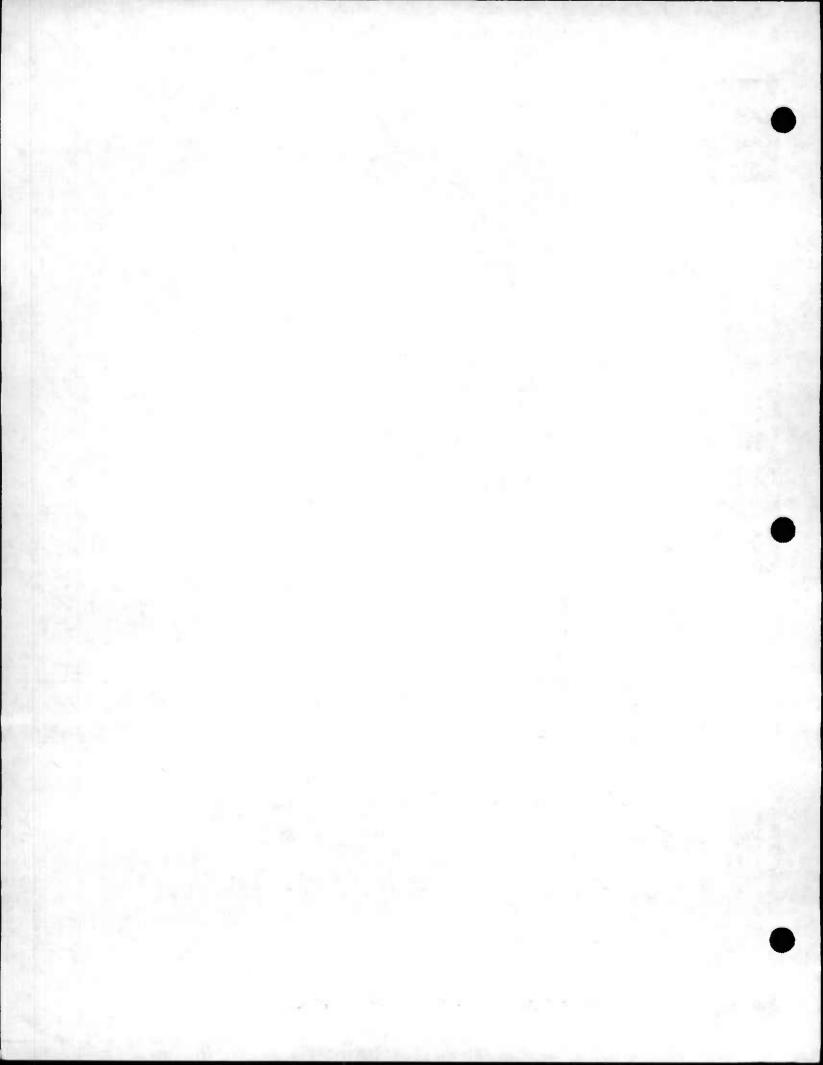


State of Maryland / Department of Health and Mental Hygiene 00 22285

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/Medical Examiner	4a Facility Name (If not institution, give 5826 Shookstor				ib. City, Town, o Frederi	r Location of Death	4c. County o				
Funeral Director	219 20 9971	7. Aga (In yrs. 74)	last birthday) If Un Yrs. Monti	dar 1 Yaar ns Days	If Undar 24 H Hours Mi		Yes 1925	9. Birthplece (Stata or Foreig Mary Land			
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	11. Marital Status 1 Navar Married 2 Married 3 Widowed 4 Divorced	12. Was Decedant Ever in U. Armed Forces? 1 Yas 2 No If Yas, Giva 1 Yaar or Datas:	If Vac s	13. Was Decedant of Hispanic Origin? (Specify Yas or No- If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1□ Yes 2□ No Specify: 1□ Yes 2□ No Specify: Specify: White							
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d 2 should the and Men T is marked traumatic.	Millard Carr 19a. Informant's Name/Ralationship (7 Carroll Plowman)	ype, Print)	19b. Malling Addr		and Number or	Rural Route Number		or Town, State, Zip Code) Md. 21702			
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if flam 27 is marked other than any injury or other traumatic avent, the Manse. To Be Compl.	20a. Method of Disposition 1 Burlel 2 Cramation 3 4 Donation 5 Other (Specify	Ramoval from Stata Fa	lace of Disposition (in emptory of the United C	Vama of or other place hurch	Cemetery,	June 30, 20	20c. Location - C	City or Town, Stata rlesville, Mo			
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State of Maryland / Department of Health and Mental Hygiene 10 22285

			Certific	ate of Death		Reg. No.	0 22201				
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/Medical	Kenneth Mark				June 2	-	3:50 p				
Examiner	4a Facility Neme (If not Institution, give	wn, or Location of Dea									
	5. Social Security Number 6. S	morial Hospita		nder 1 Yeer If Under:	derick		ederick 9. Birthplece (State or Fore Country) West Virgir				
Funeral Director	5. Social Security Number 235-38-3185 6. Sex 7. Age (In yrs. last birthdey) 72 Yrs. Hours Min. 3. Date of Birth Months Days Hours Min. June 3, 1928 9. E. Usuet Residence of Decedent										
2	10a. State 10b. County	10c. C	ity, Town or Location				10d. Inside City Lim				
or 28e-f short be notified at Director		lerick		Frederick			1 □ Yes 2 💢				
	10e. Street and Number 4882 Blue Sprud	e Lane	101	Zip Code 217	03	10g. Citizen of Wh	S.A.				
iner must	11. Merifal Status	12. Was Decedent Ever in I	12. Was Decedent Ever in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl				- American Indien, , White, etc.				
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leal ted	15. Decedent's Ed (Specify only highest gre	lucation	16a. Decedent's	Jsuel Occupation work done during mos	t of working	16b. Kind of Bus					
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be a c	Lonnie L. Polir	ng			Ethel R. S	Shahan					
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27	Rhea Metzer Polin	ıg/Wife	4882 Bl	ue Spruce L	ane, Frede	erick, Mar	yland 21703				
y or oth	20a. Method of Disposition 1 \(\text{DBuriat} \) 2 \(\text{Dcremation} \) 3 \(\text{Removel from Stete} \) 4 \(\text{Donation} \) 5 \(\text{Other (Specify)} \) 20b. Place of Disposition (Name of camelery, crematory or other place) 3 \(\text{Removel from Stete} \) 5 \(\text{Marks Lutheran Church Lutheran Church} \) 3 \(\text{Date} \) 20c. Location - City or Town, Step camelery, crematory or other place) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Date} \) 20c. Location - City or Town, Step camelery, crematory or other place) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Date} \) 3 \(\text{Date} \) 3 \(\text{Date} \) 6 \(\text{Marks Lutheran Church} \) 3 \(\text{Date} \) 20c. Location - City or Town, Step camelery, crematory or other place) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Date} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Date} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(\text{Marks Lutheran Church} \) 3 \(Marks										
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page 2 should	DEMENTI	H				rformed?	available prior to completion of caus				
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certificate ha	00.144						1 Yes 2 No				
s certific director.	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:	7500	Other	of Deeth (Check on)						
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To the Funeral Director: After this completely filled in by the funeral Medical Certification: 1	(Check only 2 Medical Exam	ysician: To the best of my kn niner: On the basis of examin									
To the Funeral Completely filled	one)	end manner stated.									
000	29b. Signature end title of certifier	1 Un				(Month, Dey, Year)					
124	funk 1. 16	- 10		111/11		Julie 24	, 2000				
	30. Name end address of person who	completed cause of death (Ite	om 23a) (Type, Print)	11,0 -217	n	- 14					
ST.	28/ Thums Joh,	non luve H	CONFRICK	MD 217	02-						
State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign	nature	Locale	5						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day JULY Physician 2, 2000 JOHANNA DOROTHEA **PORRO** 7:20 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner LaPlata Charles County Nursing & Rehab. Center Charles 7. Age (In yrs. last birthday) If Under 1 Yeer If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Dec. 10,1921 Birthplece (State or Foreign Country) **Funeral** Days 1 M 2 F Yrs. 579-90-2835 78 Germany Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examples must be notified at once. 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Maryland Charles Waldorf 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2504 Gittings Court 20602 U.S.A. Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yas 2 DNo If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 X No Specify: Specify: þ 3X Widowed 4 □ Divorced White Completed 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be (Unavailable) Ernest Windeler Meta 2 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2504 Gittings Court, Waldorf, Maryland 20602 Michael Porro/Son 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cremetion 3 Removal from State Arlington National Cem. 07-11-2000 Arlington, Virginia 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Juneral Service License 22. Name end Address of Facility JOHN P. KNISLEY The Huntt Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory arrest,

Approximately 100HN P. KNISLEY 101164 P.O. Box 156, Waldorf, Maryland 20604

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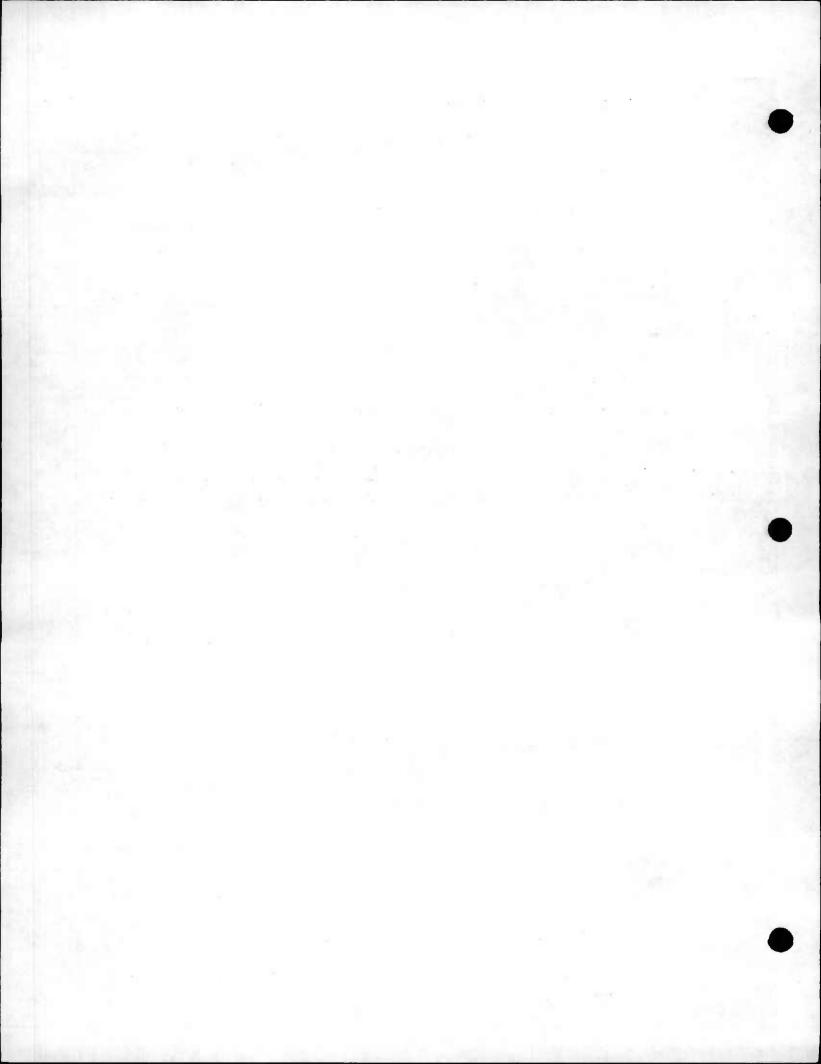
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JUL 0 5 2000 32. Registrar's Signature State

DHMH 16 Rev 6/95

Registrar

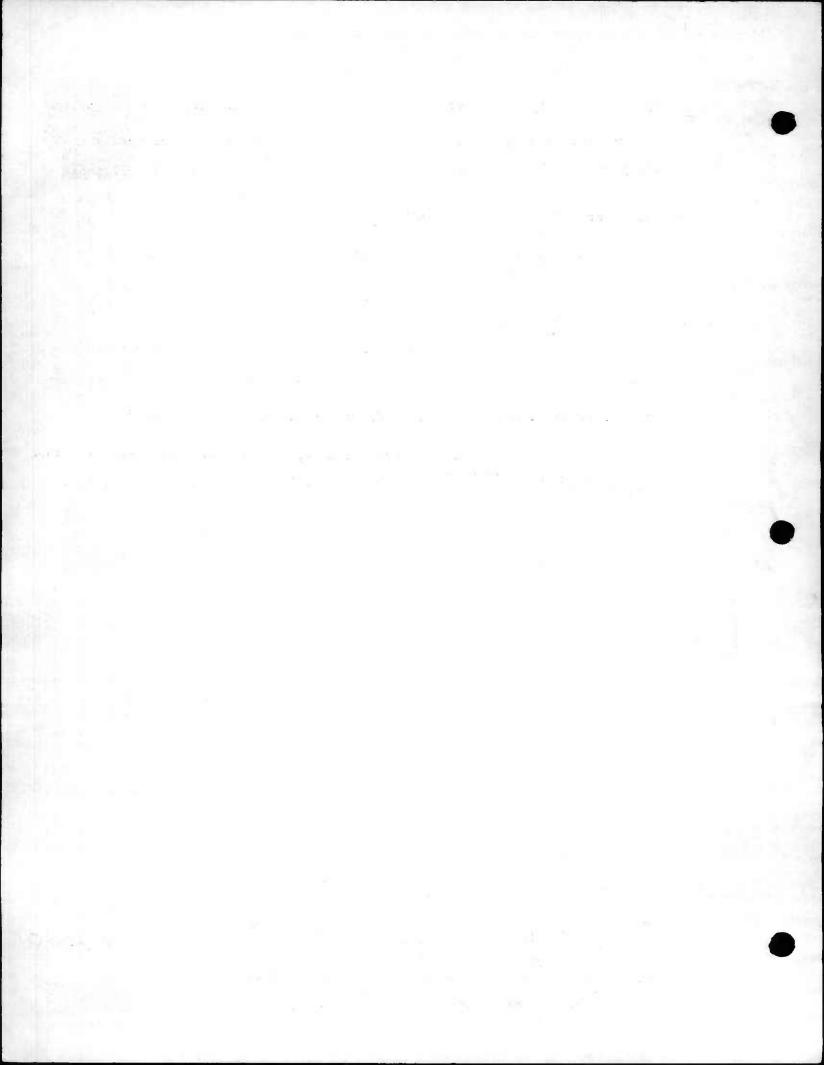


State of Maryland / Department of Health and Mental Hygiene

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			1. Decedent's Name (First, Middle, Last)					2. Date of Death)		3. Tima of Death		
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1	/Medi		4a. Facility Name (If not institution, give		LK		4b. City, Town, or L		4c. County	of Death	J. Jopin		
ji.	Examii	ier											
-	-		St. Catherines 5. Social Security Number 6. Sec		vrs. lest birthda	(v) If Under 1 Yea	Emmitst r If Under 24 Hrs.	8. Date of Birth	Fred	erick			
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			Usual Residence of Decedent	81				Aug. 18,	1918	TITI	inois		
	and w		10a. Stata 10b. County	100	. City, Town or	Location				10	Od. inside City Limits		
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	188 H	Director	10e. Street and Number	K.	THULING	10f. Zip Code		145	a Ohiana at N	10	- 14		
	E P E		Toe. Street and Number			Toil. Zip Code		10	g. Citizen of V	vnat Count	.ryτ		
	ath 23	Funerai	125 Cody Dr. Ap	t.#22		21788			USA				
	or de	une		Was Decedent Ever Armed Forces?	in U,S. 13	 Was Decedent of If Yas, specify Cu 	Hispanic Origin? (Sp ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)		e - America k, White, e			
20	filed within 72 hours efter death with the Meryland Hygiene. ther than "natural", or Items 23s or 28s-4 show ont, the Medical Examiner must be notified at		1 Never Married 2 Married	1 X Yes 2 ☐ No If Yes, Give	WW II	1 ☐ Yes 2 ☑ No	Specify:		Specify	. Whi	te		
Ö	on L	d by	3 Widowed 4 Divorced	Yaar or Dates:	*****				- CP COM/				
21215-0020	72 hant	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	16a. Dec (Gh	edent's Usual Occi ve kind of work don	upation e during most of work ed)	ding 1	6b. Kind of Bu	usiness/Ind	ustry		
<u>2</u>	ig ig	npi	Elemantery/Secondary (0-12)	Collega (1-4or 5+)	life	DO NOT use retir	ed)						
	No par	S	12	100	Owne	er Operat	or		Metal F	abric	cation Co.		
p	A de ta	Be	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middla, N	leiden Sumem	na)			
/la	yent Went rked rice	10	Frank	E	avek		Francis	5		Cu	pstein		
Maryland	of Direction		19a. Informant's Name/Relationship (Ty	pe, Pnint)	19b. Ma	lling Address (Stree	et end Number or Ru	ral Route Number,	City or Town,	State, Zip	Code)		
	alth 27 is		Mary E. Pavek (Wife)	125 (Cody Dr	Apt. #22	Thurmor	nt. MD	21788	3		
re,	of Hee		20a. Method of Disposition		b. Placa ot Dis	position (Neme of			Oc. Location -				
Baltimore,	ege orto		1 Burial 2 Cremation 3 R			emetory or other pi		100100					
Ē	Train of	1	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License			ing Crema 22. Name and Add		5/28/00 8	Smithsb	urg,	Maryland		
Ba	permit. Peges 1 end 2 should be filed within 72 hours efter death with the Merylan Department of Health and Mental Hygiene. Important: if fern 27 is marked other than "natural", or items 23a or 28a-f show important: if fern 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Wed cal Examiner rust be notified at 200.8.		21. Signature of Furieral Service License	10	_		Dailey &	Son Fune	ral Ho	mes	ΡΔ		
			1		-	15 F. Ma	in St. Tl	urmont.	MD 217	88			
ľ			23a. Purit. Enter the disease, or complianock, or heart feilure. List only on	cetions that causad that	daath. Do not a	nter tha mode of dy	ing, such as cardiac	or raspiratory arre	st,		Approximata Interval Between		
T	Physician		2000 000 000 000								Onset and Death		
	/Medical		immediate Cause (Final disease or condition resulting in deeth) a. Couses five heart failure 2 day S. Due to (or as a consequence of):										
И	Examiner		resulting In deeth)	Due	o (or as a cons	edneuca ot).	gailu	/00		10	aug.		
		je				2 8 2	· / No		2	1	· che		
	eath certificete be executed ettending physician end for use as the bunal-transit	Examiner	Sequentially list conditions. b. End Stack Renal Disease 1 47. Sequentially list conditions.										
Ć,	exection of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the fi	EX	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	RI.	1	/	ANTI.	L'D		-	20.19		
9/	e be Sicia	edical	Cause (Disease or Injury that initiated events	- May	o (or as a cons	5 C 7	Mu	1/28			TIP.		
68760,	ficet phy s th	Pa	resulting In death) Last	Dua	o (or as a gons	equence or):		/					
ŏ	certi	3											
ŭ	The law requires that the death certate hes been signed by the ettending page 2 should be detached for use	Physician											
o.	the d	ysi	Part il. Other significant conditiona con	tributing to death but not	resulting in the	underlying cause g	iven in Part I.	23b. Did tot	DECCO USE CO	ntribute to	the cause of death?		
Δ,	d by	4	Stopla . udo	oficia à	TR	· 0 C	DONT	1 🗆 Ye	2 No	3 Prob	ably 4 Unknown		
Records,	es ti	b	The state of	7000		-aar	OICI						
50	v require been si should	Completed	acc	283				24a. Was an perform		ava	re autopsy tindings illable prior to		
ပ္က	s be	pie								con of d	npletion of causa leath?		
	he le ege	E						1 □ Ve	a 2 √2 No	10	Yes 2□ No		
ta			25. Was case reterred to medical				ne Place of Dec				2010		
5	ysicien: The law s certificate hes b director, page 2 s	o Be	evaminer?	ospital:	. □ ED/O	00 004 0	ther	th (Check only one		40. 14			
ō	2 0 0	5	27. Manner of Death	1 ☐ Inpatient 28e. Dete of Injury	2 ER/Outpati		46	oma 5 Resider)		
Division of Vital	After funer	io	1 Maturai 5 ☐ Pending	(Month, Dey Yea	r) Injury	W	ork? ☐Yes 2☐No		,u.y coou				
S	deat deat tor:	Ca	3 ☐ Suicide 6 ☐ Could not be	090 Diese at Injune	At home town			28f. Location (Str	nat and Numb	or or Bush	I Coute Number		
2	P # # =	Certification:	4 ☐ Homicide determined	28e. Piaca ot Injury - a building, atc. (Sp.		street, factory, office		City or Town,		er or norar	Hodia Mulliper,		
	rai co												
	To the Hospital or Attending Ph within 24 hours effer death. To the Funeral Director: After thi completely filled in by the funeral	edical	(Check only 2 Medical Examin	ician: To the best of my er: On the basis of exar	knowledge, dee ninetion end/or	oth occurred at the tring in my	time, date and piaca, opinion, death occur	and due to the ca red at the time, da	use(s) and ma te and placa.	nner as sta and due to	ited. the cause(s)		
	the I	Ped	one)	and manner stated.							<u> </u>		
	S S S	Σ	29b. Signatura and title of cartitier		\cap	290, Licer	4405	29	d. Date signed	a (Month, E	Jey, Year)		
			Dozwitalik	REMARKS	1-18	train	7	J	une	28.	2000		
			30. Neme and address of person who co	pupleted cause of death	(Item 23a) (Type	Print)				, 0/			
			Bonita Portier		Vater S	t., Thurm	ont, MD 2	1788					
	Sta	te	31. Date tiled (Month, Dey, Year)	32. Registrers S		- 1.	LILL, III Z	2,00					
	Registr		HIN O A	anna A se	in	19	know W						

DHMH 16 Rev 6/95



rica		Print In Black of Maryland								22200
	State	n Marylanu	-	rificate c				Reg. No.	10	22289
1. Decedent's Name (First, Middle	, Last)			Pall 1	1000		2. Date of De	ath	Vane	3. Time of Deeth
Elizabeth	Robinso	n					June 25	, 2000	Yeer	4:00 A.M
4e Facility Neme (If not Institution	, give street and ne	mber)			4b. City, T	own, or Le	ocation of Death	4c. Cour	nty of Death	
9218 Cranda	11 Road				Lanh	am		Prince	e Geo	rges
5. Social Security Number 577-42-5364	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs. las	t birthday) Yrs.	If Under 1 Ye Months De		r 24 Hrs. Min.	8. Dete of Bir (Month, Da April I	0,1931	9. Birth Con New	nplece (State or Foreign untry) York
Usuet Residence of Decedent										
Maryland Prince	Georges	Lan	Town or Loc ham	ation						10d. Inside City Limits 1 ☐ Yes P No
10e. Street and Number 9218 Crandall	Road			10f. Zip Cod	20706			10g. Citizen d	Whet Co	untry?
11. Mental Status 1 Never Merried 2 Merri 3 Widowed 4 Divorced	12. Wes Dec Armed F 1 Yes If Yes, G Year or I			as Decedent of Yes, specify C			ecify Yes or No Rican, etc.)	Spec	lack, White	icen Indien, , etc. hite
15. Decedent (Specify only highes Elementery/Secondery (0-12)	t grade completed		(Give k	ent's Usuel Oc ind of work do O NOT use rei	ne <i>dunina</i> mo	st of work	ing	16b. Kind of	Business/I	ndustry
12			Нс	omemake	r	TON.		Own 1	Home	
17. Father's Neme (First, Middle, a unobtainab		straat			18. Moth	ner's Nem	e (First, Middle, un	Maiden Sum obtain:		
Brenda W. Crews 20e. Method of Disposition Wasurial 2 Cremetion 4 Donetion 5 Other (Sp. 21. Sprature of Funeral Service I	-Bell / I	20b. Pled carr	11344 ce of Dispos netery, cremo Lincol	Cherr ition (Neme of etory or other) In Ceme	y Hill olece) tery	Rd.	#303 B Date 29, 20 Linco	eltsvi 20c Locatio 00 Brei	lle, l n-City or l	MD 20705 Fown, State
A Mayor	4 The	elal					d. Bren			
The Part Enter to disease, or prock or heart failure. List	complications that only one cause on	ceused the deeth. eech line.	Do not ente	r the mode of	dying, such e	s cardiec	or respiretory e	rrest,	1	Approximete Intervel Between Onset end Deeth
Immediate Cause (Final disease or condition resulting in deeth)	a. Pt	lmonary	Distre	ess	33.5				1	
rosumy in coolin	, O	Due to (or a varian Ca	s e consequ ncer	ence of):						
Sequentielly list conditions, if any, leeding to immediate cause. Enter Underlying Couse (Disease or injury		Due to (or e	s a consequ	enca of):					5,12	
that initiated events resulting in death) Last	d	Due to (or e	s e consequ	enca of):						
							1			
Part II. Other aignificant condition	na contributing to o	leath but not resulti	ng in the und	derlying ceuse	given in Peri	1.	1 1 2 2 2	Yaa 2 🖾 No		to the cause of death? obably 4 Unknown
							24e. Wes	an eutopsy rmed?	8	Were autopsy findings available prior to completion of ceuse of deeth?
							10	Yes XX No	1	☐ Yes 2☐ No

Physician /Medical Examiner

The lew requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the bunal-transit

Division of Vital Records, P.O. Box 68760,

Physician

/Medical

Examiner

Funeral

Director

ir than "natural", or Nems 23a or 28a-f show the Wedical Examiner must be notified at

Funeral Director

Be Completed by

2

permit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygers. Important: If them 27 is marked other than "natural", or items 23s or 28s-f show

Baltimore, Maryland 21215-0020

Examiner Sequentielly list condition if any, leading to immedicause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

1 Yes 2X No

27. Menner of Death

1 X Naturel

2 Accident

3 Suicide

29e. Certifier (Check only one)

4 Homicide

Completed by Physician/Medical

Be edical Certification: To

To the Hospital or Attending Physician: The lew within 24 hours after death.

To the Funeral Director: After this certificate has it completely filled in by the funeral director, page 2.

0

State Registrar

29b. Signetuse and title of cartifie

5 Pending Investigation

6 Could not be determined

Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number D0047612

28c. Injury et Work?

1 Yes 2 No

29d. Dete signed (Month, Dey, Year) June 28, 2000

281. Location (Street and Number or Rurel Route Number, City or Town, Stete)

Other: 4 Nursing Home 2 Residence 6 Other (Specify)

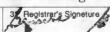
28d. Describe how Injury occurred

30. Nema and address of person who completed cause of deeth (Item 23a) (Type, Print)

Paul MacKoul, M.D. 110 Irving St. NW Washington, DC 20010

28e. Dete of Injury (Month, Day Year)

31. Dete filed (Month, Day 9 2000



Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA

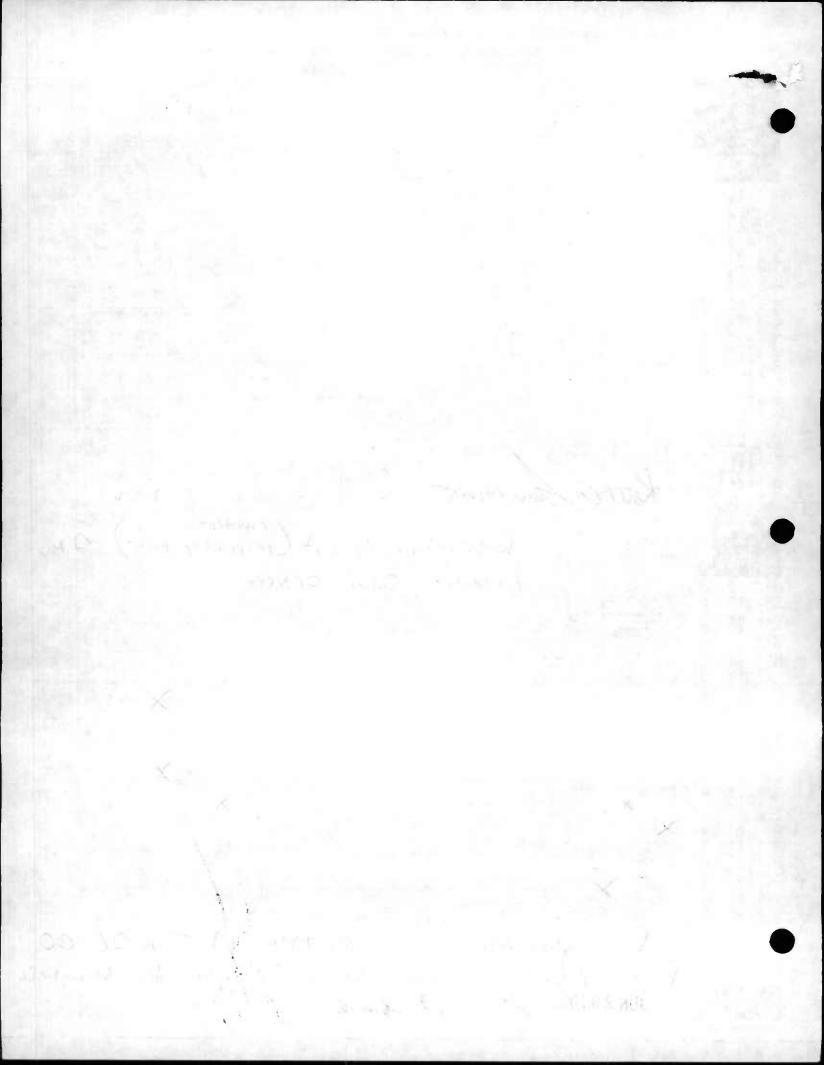
28b. Time of Injury

28e. Plece of Injury - At home, farm, street, factory, offica building, etc. (Specify)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

nysician Medical	1. Decedent's Na	me (First, Middla, La	ist)		11.00			2. Date of Month	Death Day	3. Time of De
	SARAH	IDA RAYNO)R					JUNE	24,2000	2:10p
niner		(If not institution, giv		er)				or Location of De	ath 4c. County	of Death
		NELL PLAC					FOREST			NCE GEORGES
eral tor	5. Social Security 578-26- Usual Residence	7535	Sex 7.	Age (In yrs. 84	last birthday) Yrs.	Months Days		in. 8. Date of (Month, SEPT	Birth Day, Year) 18,1915	9. Birthplace (State or Fo Country) SOUTH CAROI
	10a. State	10b. County		10c. Ci	ty, Town or Loc	ation			W. D. L. L.	10d. Inside City L
tor	MD	PRINCE (GEORGES		FORESTV	ILLE				XX Yes 2
Funeral Director	10e. Street and N 7170 DO	umber ONNELL PLA	ACE			10f. Zip Code 20	747		10g. Citizen of V UNITED	
by		rried 2 Married	12. Was Decede Armed Force 1 Yes 2 If Yes, Give Year or Date	eş? ZNo		/as Decedent of l Yes, specify Cub ☐ Yes 2 🗓 No		(Specify Yes or parto Rican, etc.)	No- 14. Rac Blac Specify	a - American Indian, ck, White, etc.
Completed	Elementary/Sec	15. Decedent's E ecify only highest gra- condary (0-12)	ducation ade completed) College (1-4	or 5+)	(Give I	ent's Usual Occu sind of work done O NOT use ratire	during most of e	working	16b. Kind of Bu	usiness/industry
S	12 Fethar's Name	(First, Middle, Last	1		SEAR	SIKESS/	_	Jame (First Mide	dle, Maiden Surnam	
To Be	NORMAN	DAVIS SR	38.11				ADDIE	ROUSE		
		Name/Relationship (mber, City or Town,	
	ADD LE B.	EATTY / DA	AUGHTER	20b. I				Date	VILLE, MD	City or Town, State
	1 🔯 Burial 2	Cremation 3				atory or other pla		1100		INGTON, VA
۸.		5 Other (Special uneral Service Lice	-	AK						INGION, VA
Elementary, The property of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of the first of th		-10	//			ALEXAND	ER S. PO	PE FUNE	RAL HOME	
	Nei	the disease or com art failure. List only	Tung M	1085					TVILLE, MD	20747 Approximate
or or use as me bunal-trensit	Sequentially list of any, leading to cause. Enter Und Cause (Disease of that Initiated ever resulting in death	conditions, immediate derlying or Injury ts Last	b. Me		or as a consequence or as a consequence		CAN	en		
Physician/M			d	-						
sicia	Part II. Other eign	ificant conditions	contributing to deat	h but not res	sulting in the un	derlying cause g	iven in Part I.	23b. D	ld tobacco use co	ntribute to the causa of c
Phy								1	□ Yee 2006	3 ☐ Probably 4 ☐ Un
Completed by Physician/M		4 8/6		47.5				24a. W	as an autopsy erformed?	24b. Were autopsy find available prior to completion of caus
mp									- >	of death?
ပိ	OF Was some refe	and to medical					00 50 1		Yes 2 No	1 ☐ Yas 2 ☐ No
o Be	25. Was case refe axaminer?	No Medical	Hospitai:	ationt OF] ER/Outpatient	3 DOA OI	ther: 4 Nursin	Death (Check on	esidenca 6 □Oth	os (Cassiful
	27. Manner of Dec	•	28a. Date of	Injury	28b. Time of	28c. tnju			be how injury occur	
H	1 Natural 2 Accident	5 Pending investigation		Day Year)	Injury		ork? ☐Yes 2☐No			
ation: T	Z II ACCIOMITE	6 Could not b	ZOA. PIACE U	Injury - At h	ome, farm, stre fy)	et, factory, office		28f. Locatio City or	n (Street and Numt Town, Stata)	ber or Rural Route Number
ertification: T	3 Suicide 4 Homicide	determined								
dical Certification: T	3 Suicide 4 Homicide 29a. Certifier (Check only	determined	niner: On the basi	s of examina	owledge, death ation and/or inv	occurred at the t estigation, in my	ima, date and pl opinion, death o	aca, and due to t	he cause(s) and mine, date and place,	anner as stated. and due to the cause(s)
Medical Certification: To	3 Suicide 4 Homicide 29a. Certifier	1 Certifying Pt	nyelcian: To the be niner: On the basi and manner	s of examina	owledge, death ation and/or inv	estigation, in my	ima, date and pl opinion, death o	aca, and due to t	ne, date and place,	anner as stated, and due to the cause(s) ad (Month, Day, Year)
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State of Maryland / Department of Health and Mental Hygiene

					Cei	rtifica	ite of i	Death			Reg.	No.			
		1. Decedent's Neme (First, Middle	, Last)	A 1430		-81 /	300		335	2. Dete of		Davi	Vana	3. Tima of	Death
	Physician	Bernadette	Fran	ces	Rome	e0				June		Day 2000	Yeer	3:45	am
	/Medical	4e Facility Neme (If not institution			ROM		4	b. City, To	own, or Lo	ocation of De		4c. County		3.43	aiii
	Examiner						20	Tanh						1-	
_		7548 Newberry 1	6. Sex	7. Age (In yrs	lant histhelau)	If Unc	ler 1 Year	Lanh		P Date of	Dieth			orge's	
	Funeral		1 M 2 F		Yrs.	Month		Hours	Min.	8. Date of (Month,	Dey, Ye	ar)	9. Birthp	lece (Stete o	or Foreign
	Director	200-20-0461 Usuel Residence of Decedent		72	110.					Jan.	27,	1928	Penn	sylvar	nia
	B .	10a. Stete 10b. County		10c. C	ty, Town or Lo	cation	-						1	0d. Inside C	thy Limits
	sho	100.000.1)			.,,										2□No
	octo		e George'	s Lar	ham									M'A'100	2010
	or 28s-f so notified	10e. Street and Number				10f. 2	ip Code				10g.	Citizen of	Whet Coun	try?	
	w th w	7548 Newberry La	ane			2	0706				U.	S.A.			
	72 hours effer death with the Maryland natural", or heme 23e or 28e-f show disal Evantinet must be notified at eted by Funeral Director	11. Meritel Status		edent Ever in U	J,S. 13.	Wes Dec	edent of H	ispenic Or	Igin? (Sp	ecify Yes or Ricen, etc.)		14. Rac	e - Americ		
0	or ha	1 Never Married 2 Marri	ed 1 TYes	2FMo	200					ricen, etc.)			ck, White,	BIC.	
02	by By	3€Widowed 4 □ Divorced	If Yes, G Yeer or I	ive Detes:		1 LI Yes	2€ No	Specify				Specify		nite	
9	"natural", oral Eu	15. Decedent	's Educetion		16a. Deced	dent's Us	uel Occup	etion			16b	. Kind of B			
21.5	S	(Specify only highes			(Give	kind of v DO NOT	vork done d	du <i>rin</i> g mos	of work	ing					
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DHMH 16 Rev 6/95

Registrar

State of Maryland / Department of Health and Mental Hygiene 00 22292

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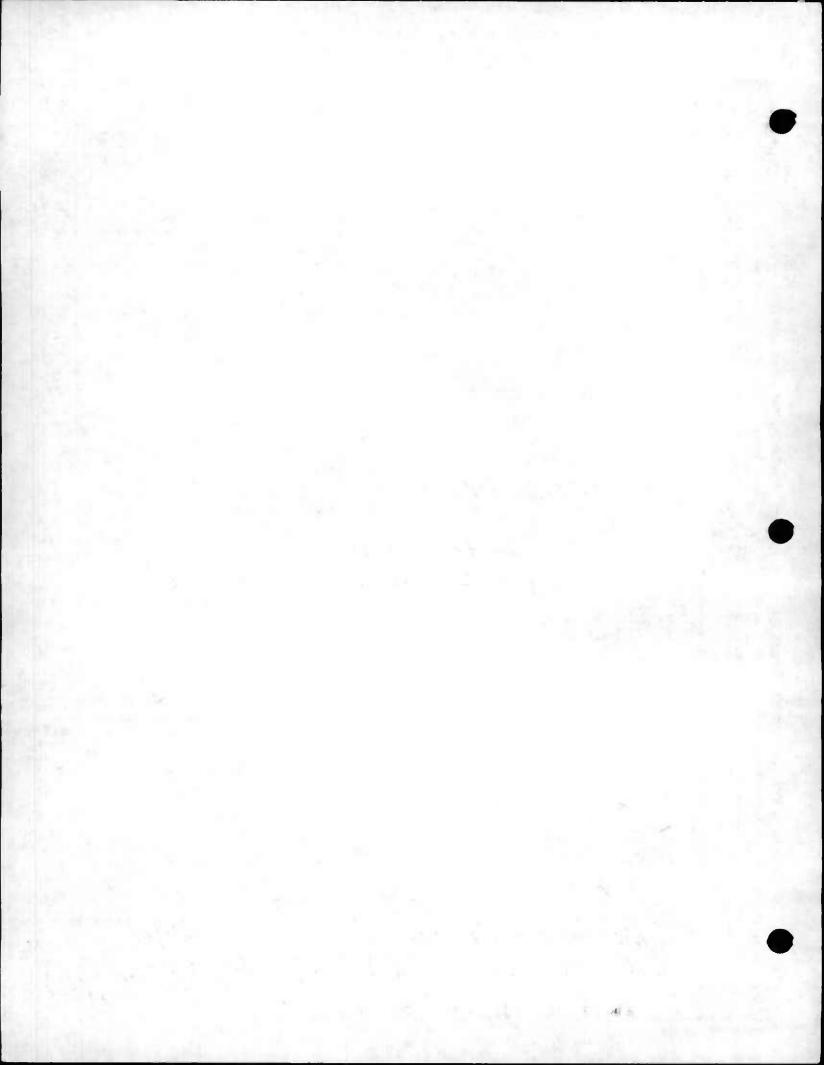
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State of Maryland / Department of Health and Mental Hygiene

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Physician	1. Decedent's Nema (First, Middle		Mary 1				2. Dete of Death Month Day Y		3. Time of Dec	
/Medical		Edwards	Piero	e Robe	erson	May		000	9:37	PM
Examiner	4e Facility Neme (If not institution Frederick	n, give street end numb Memorial				r Location of Dea				
unaval	5. Social Security Number		Aga (In yrs. lest birtl	dey) If Under 1 Year	r If Under 24 H		irth		rick placa (State	or Foraign
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28a-f ahow notified at rector		rederick	Toc. City, Town		derick				10d. Inside C	2 No
ust be notified at rai Director	10e. Street and Number			10f, Zip Code			10g. Cifizen of N	Whet Cou	ntry?	
unt be	228 Thames Dri	ve			2170)2		U.S.A		
nera	11. Meritel Status		ent Evar in U,S.	13. Wes Decedent of If Yes, specify Cui					can Indian,	
by Funeral Director	1 Never Merried 2 Merried 3 Widowed 4 Divorced	Specify:	sito riioan, otc.,	Specify		nite				
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any injury or o	1 Buriel 2 ☐ Cremetion 4 ☐ Donetion 5 ☐ Other (S		oto	ven Memoria		s June	5, 2000	Fre	ederic	k, M
ne deeth certificeta be executed the attending physicien end hed for use as the burisl-transit ysician/Medical Examiner	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that infiliated events resulting in deeth) Lest	c	Due to (or es a co		MONEC	Carce	202			
be detached for use by Physician/N	Pert II. Other significant condition	ns contributing to deal	h but not resulting in	the underlying cause g	iven in Pert I.	23b. Di	d tobacco uae co	ntribute t	o the cause	of death?
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Should							es en eutopsy formed?	av	fere autopsy veilable prior omplation of death?	to
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ital or Attending Purs aftar death. Ital Director: After to lied in by the funers Certification:	27. Menner of Death 1 Neturel 5 Pendin 2 Accident investig	getion	Injury 28b. To Dey Year) In	ury W	ury et ork? □ Yes 2 □ No	28d. Describ	e how injury occur	red		
	3 ☐ Suicide 6 ☐ Could (determ	ined 286. Piece of	I Injury - AI home, fer , etc. <i>(Specify)</i>	n, street, factory, office	n (Street end Number or Rurel Route Number, Town, State)					
	29a. Certifier 1 Certifyin (Check only one) 1 Medical	g Physician: To the be Examiner: On the basi end manne	is of examination and	deeth occurred et the for investigation, in my	time, date and pla opinion, deeth oc	ce, and due to the	e cause(s) and m e, date and place,	anner as a	stated. to the cause((s)
compl		P.FOZ		DO	03666	,	29d. Date signe 6 [1] 0	Month.	Day, Year)	
	30. Name and address of person NICKOLDS	who completed cause, P'FD RIS	ot deeth (Item 23a) (4 Tho Kes	is Jou	Alex For	Dein.	50	n mo	0
State	31. Date filed (Month, Dey, Year)	000 6	elstrer's Signeture	4 1	,	1			2170	71

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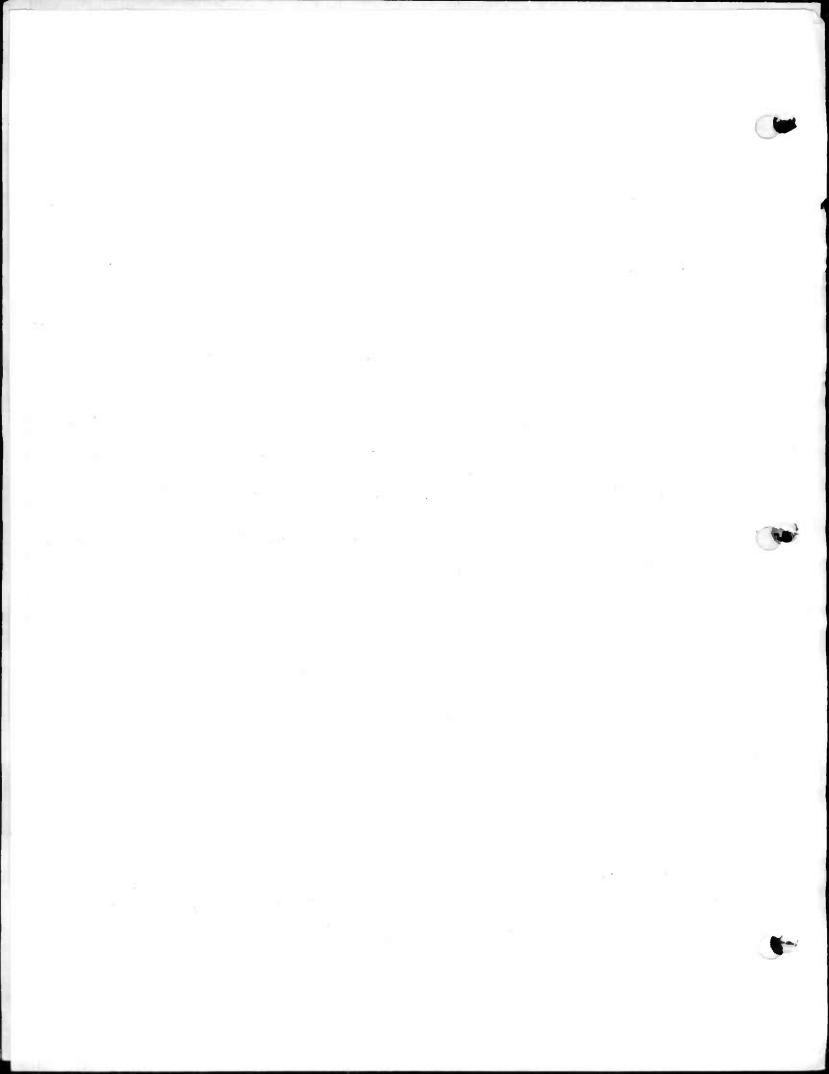
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** JOHN EVERETT RUSSELL June 26 2000 9:45 PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Talbot Easton Genesis ElderCare The Pines If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days M 2DF 90 Yrs 214-18-4999 1910 MARYLAND Director 14, Usual Residence of Decedent the Meryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "natural", or itema 23s or 28a-f show other traumatic event, the Medical Examinal must be notified at MD TALBOT YOS 2 No EASTON Director 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? with 610 DUTCHMAN'S LANE 21601 U.S.A. death Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 27 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hygiena. Important: If Item 27 is marked other than "natural", or hern any injury or other traumetic event, the Menters and an Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0020 1 Yes 2 No Specify: WHITE Specify: þ 3 XWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE FOREMAN BOAT MAINTENANCE 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Russel JOHN RUSSELL ELMIRA ELLISON 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PATRICIA ANN POTTER/NIECE 104 RICHARDSON STREET, OXFORD, MD 21654 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20e. Method of Disposition Date cemetery, crematory or other place)
CHESAPEAKE CREMATION CENTER
L.L.C. 6 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHESTER, MD 6/28/00 21. Signature of Funeral Service Lice 22. Neme and Address of Facility FELLOWS, HELFENBEIN, & NEWNAM FUNERAL HOME, 200 SOUTH HARRISON STREÉT, EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart feiture. List only one cause on each line. Approximete Interval Between Onset and Death Physician dep Immediate Cause (Final disease or condition resulting in death) /Medical uma Examiner Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting In death) Last Due to (or as a consequence of): and attending physician for use as the buna Division of Vitai Records, P.O. Box 68760, Physician/Medicai Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23b. Did tobacco use contribute to the cause of death? been signed by the should be detached 2 1 No 3 Probably 4 Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed this certificate hes 2 1 No 1 ☐ Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director; to Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 1 Yes 20 No 1 Inpatient P 2 ER/Outpetient 3 DOA Nursing Home 5 ☐ Residence 8 ☐ Other (Specify) 27. Manner of Death 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \(\text{Homicide} \) To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated.

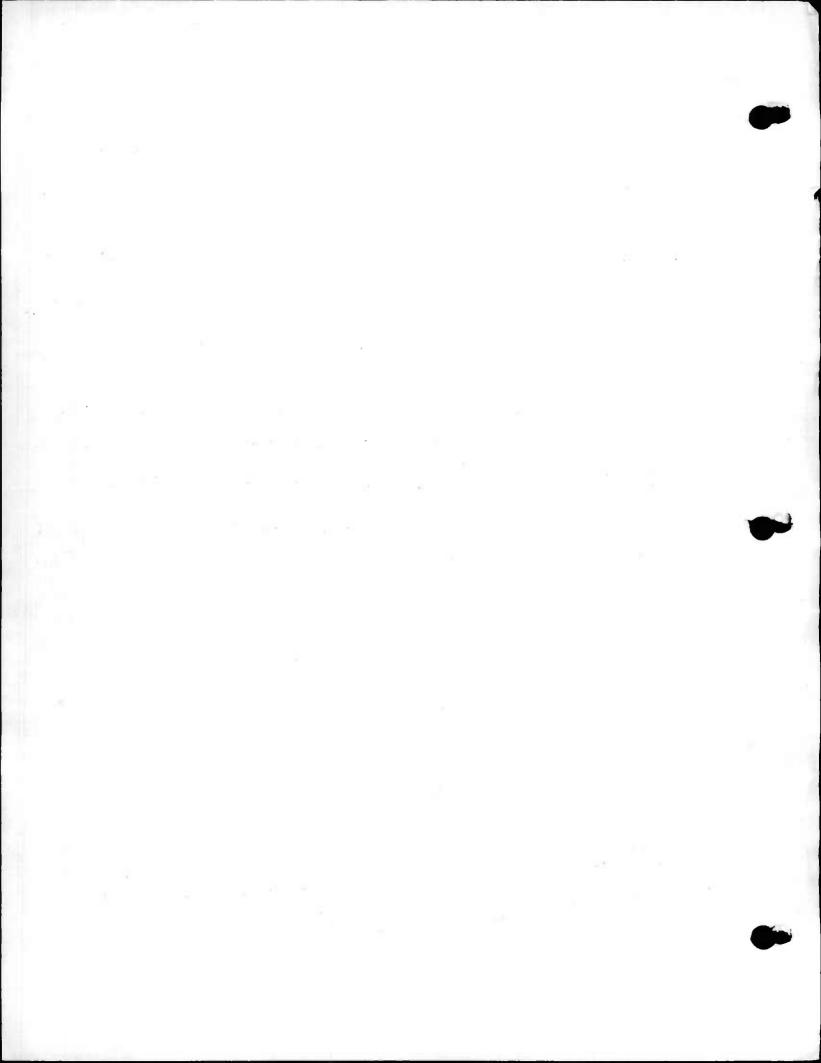
| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29d. Datersigned (Month, Day, Year) 29c. License number 29b. Signature and title of certifier COC 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 30 OBERT 32. Registrer's Signeture 31. Date filed (Month. Dev State 2000 Registrar

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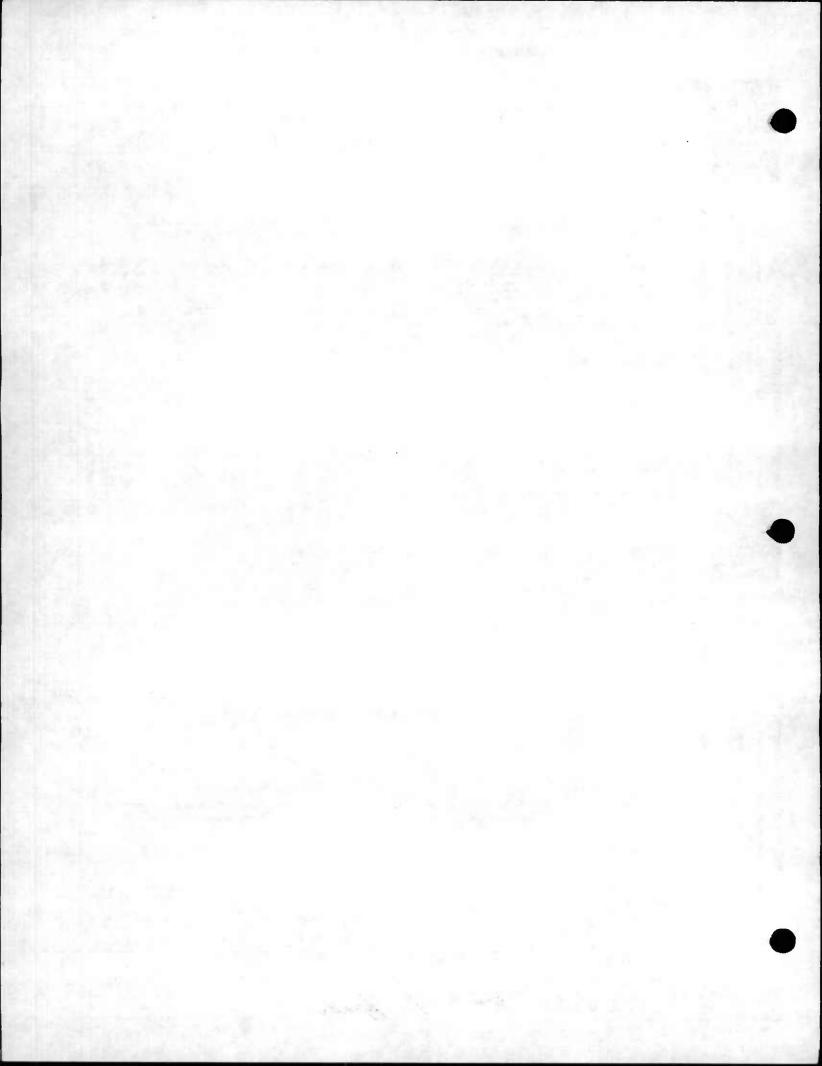
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	1 - STATE REGISTRAR	STATE OF MARYLAND /		T OF HEALTH AND E OF DEATH	MENTAL HYGIEN	E	
- (1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF OEATH
- ()	Charlotte Virginia	RIDENOUR			MONTH DA	"as 500	11:59 AM
	4. SOCIAL SECURITY NUMBER 5.	SEX 6. AGE (In yrs. lest	77	R 1 YEAR IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	8. BIR	THPLACE (State or Foreign
	215-42-3668 1 9a. FACILITY NAME (If not institution, give street	M 2 XF 76	YRS. MONTHS	DAYS HOURS MIN.	Aug 24 19:		ryland
DIRECTOR	617 Maryland Avenu			Hagerstown		Washir	0.00
3EC	10a. STATE 10b. COUNTY		10c. CITY, TOWN	OR LOCATION	-		10d. INSIDE CITY
	Maryland Washin	gton	H	agerstown			1 YES 2 NO
MAL	10e. STREET AND NUMBER			101. ZIP CODE		10g. CITIZEN OF	WHAT COUNTRY?
Ä	617 Maryland Avenu			21740		U.S	S.A.
BY FUNERAL	11. MARITAL STATUS 1	. WAS DECEDENT EVER IN U.S., ARN FORCES? 1 TYES 2 AND IF YES, GIVE WAR OR DATES	AED 13.	WAS DECENDENT OF HISPA If yes, specify Cuban, Maxic 1 YES 2 X NO Speci	an, Puerto Rican, atc.)	Bia	CE — American Indian, ack, White, atc. acify: White
COMPLETED	15. DECEDENT'S EDUCATION (Specify only highest grade com-		EDENT'S USUAL O	CCUPATION	18b. KIND OF BUS	SINESS/INDUSTRY	
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MP	V	0-2	Homemak	er	Her	own hon	ne
8	17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NA	AME (First, Middle, Maiden	Surname)	
BE	Emory Gouker				Hauver		
2	19a. INFORMANT'S NAME (Type/Print)			S (Street and Number or Rural			1 017/0
	Carol Rowland - Date 200. METHOD OF DISPOSITION		ND DATE OF DISPO	irginia Aven			
	1 N Burial 2 Cremation 3 Ramoval 4 Donation 5 Other (Specify)	from State cemetery crem	natory or other place		1	CATION — City or	
1	21. SIGNATURE OF FUNERAL BERVICE LICENS			NAME AND ADDRESS OF FU	Colon colons	h Funera	
	SCATT	MA	. (Y4	15 E. Wilson			
\neg	23. PART I. Enter the diseases, or com	plications that thused the dear					Approximata
	ahock, pr hasrt fallura. List IMMEDIATE CAUSE (Final disasse pr condition reaulting in death) a	CEREBRA!	150.50			and y arrest,	interval Between Onset and Death UEARS
N	Sequentially list conditions, b.	DEMENT A	UENCE OF):	- 4			YEAR
CERTIFICATION	if any, leading to immediate cause. Entar UNDERLYING	CENEBRA!	UENCE OF):	MEGICA	\int		1595
Ë	CAUSE (Disease or injury that initiated eventa resulting in death) LAST	DUE TO (OR AS A CONSEO					
ER	d						
	PART ii. Other aignificant conditions co	ontributing to death but not re	sulting in the u	nderlying cause givan in			46. WERE AUTOPSY FINDINGS
200					PERFOR		AVAILABLE PRIOR TO COMPLETION OF CAUSE DF DEATH?
ME							1 NO YES 2 NO
ä							
0		OSPITAL:	OTHE	26. PLACE OF DEATH (C)	neck only one)		
PHYSICIAN: MEDICAL	1 YES 2 THO 1 E	Inpatient 2 ER/Outpatient 3 28a. DATE OF INJURY	28b. TIME DF	zsing Home 5 Residence	6 Other (Specify) 28d. DEŞCRIBE HOW IF	LINEY COCHEC	
ВУ РІ	1 Naturel 5 Pending 2 Accident Investigation	(Month, Day, Year)	INJURY	WORK?	200. DESCRIBE NOW IF	NORT OCCURED	
- 11	3 Suicide 8 Could not be 4 Homicide detarmined	28s. PLACE OF INJURY — At horr building, etc. (Specify)	ne, farm, street, tec	tory, office	281. LOCATION (Street a City or Town, State)	and Number or Rura	il Route Number,
COMPLETED		e: To the best of my knowledge, dear					
	29b. SIGNATURE AND TITLE OF CERTIFIER	in the beels of examination and/or in	weatigation, in my	29c. NCENSE NU			e(s) end mennar es atated. ED (Month, Day, Year)
TO BE	30. NAME AND ADDRESS OF PERSON WHO CO	DMPLETED CAUSE OF DEATH (ITEM	27) (Type Print)	1) 22	043	6	129/00
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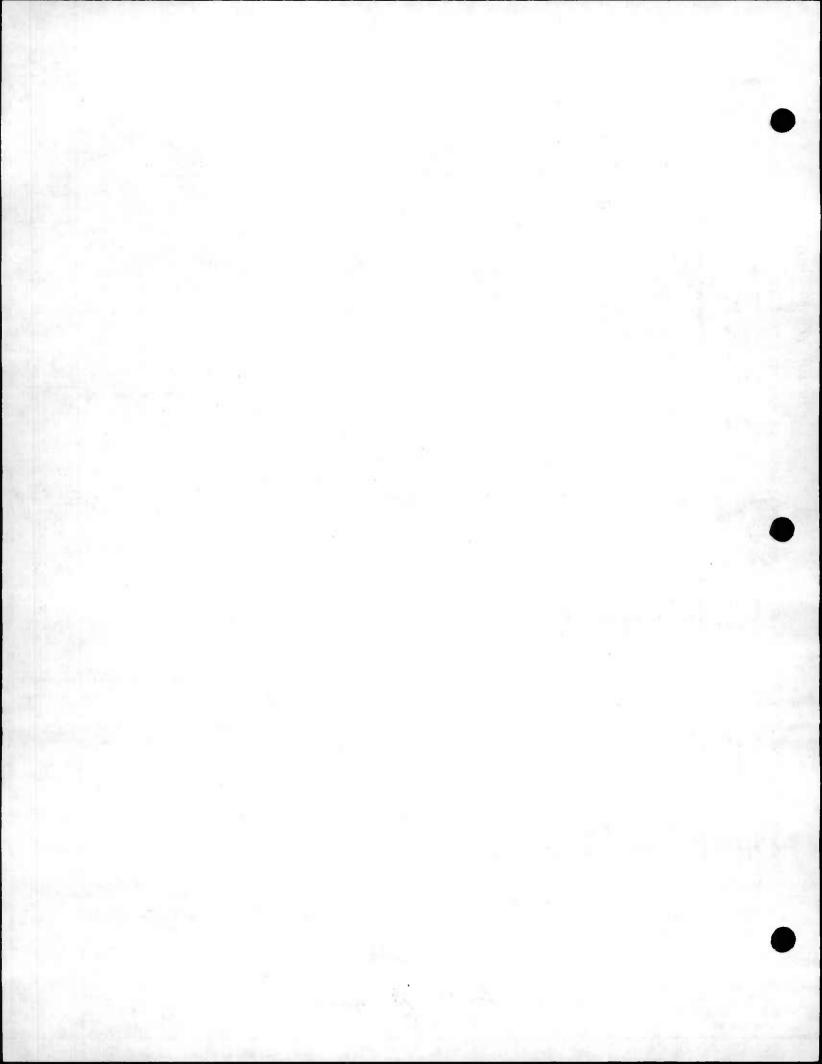
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Nama (First, Middle, Last) 2. Deta of Death 3. Time of Death **Physician** 1:15 a.m. MARY ANN RAUER JULY 03 /Medical 4a Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Western Maryland Hospital Center Hagerstown Washington 5. Sociel Security Number If Under 1 Yeer If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Feb. 22, 1922 6 Sex 7. Aga (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 25 F 154-10-4978 78 Yrs. New Jersey Director Usual Residence of Decedent 10c. City, Town or Location 10e State 10d. Inside City Limits Washington Co. Hagerstown MD 1 ☐ Yas 2 No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 8 13715 Dixie Drive 21742 U.S.A. 238 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 to No If Yes, Giva Year or Detas: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, 11 Marital Status Black, White, etc. 1 Never Merried 2 Married 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: White à 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Homemaker Own Home 12 0 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Fether's Neme (First, Middle, Last) 1 and 2 should be Health and Mental Peter Leach Catherine UNKNOWN Leach 19a. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Henry E. Rauer/Husband 13715 Dixie Drive, Hagerstown, Maryland 21742 20b. Place of Disposition (Name of cemetary, cremetory or other place) 20c. Location - City or Town, Stete Pages 1 mant of H 20e. Method of Disposition 1

Burial 2 □ Cremetion 3 □ Removel from Stete Hagerstown, Maryland Cedar Lawn Memorial Park July 7 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensea 22. Name and Address of Facility Douglas A. Fiery Funeral Home 1331 Eastern Blvd., N., Hagerstown, Maryland 21742 23d. Pert . Enter the disaase, or complications thet caused the deeth. Do not enter the mode of dying, such es cerdiec or respiratory arrest, shock, or heed feilure. List only one cause on each line. Approximete Intarval Between Onset and Death **Physician** Immediate Cause (Finel disaasa or condition rasulting In daath) /Medical HYPERA MEMMA 6 Hours Examiner Dua to (or es a consequence of):
AZ ZAZLURE Physician/Medical Examiner The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated exercises.) Box 68760 thet initiated events rasulting in death) Last P.O. 23b. Did tobacco uss contribute to the cause of death? 3 Probably 4 Donknown 1 Yss 2 No Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 ☐ Yas 2 € No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 25. Was case raterred to medicel 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 4npatient 2 ER/Outpatient 3 DOA 1 Yes 2DNo Medical Certification: To this 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Panding / investigation 1 Neturel 1 ☐ Yes 2 ☐ No death. 2 Accident Director: d in by tha 6 Could not be determined 3 Sulcide 28f. Location (Street end Number or Rural Route Number, City or Town, Stata) 28e. Plece of Injury - At home, ferm, street, factory, office building, atc. (Specify) after 4 Homicida To the Hospital of within 24 hours at To the Funeral D completely filled: 1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and dua to the cause(s) and manner as stated.
20 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, and dua to the ceuse(s) and menner steted. 29a. Certifier 29c. License number 29d. Date signed (Month) Day, Year) 29b. Signeture end title of certifier 30. Name and address of person who completed cause of death (flem 23a) (Type, Print) 1500 Pennsylvania Avenue SHAHAB DALQUI Hagerstown, MD 21742 31. Dete filed (Month, Dey, Year) State JUL 0 5 2000 Registrar



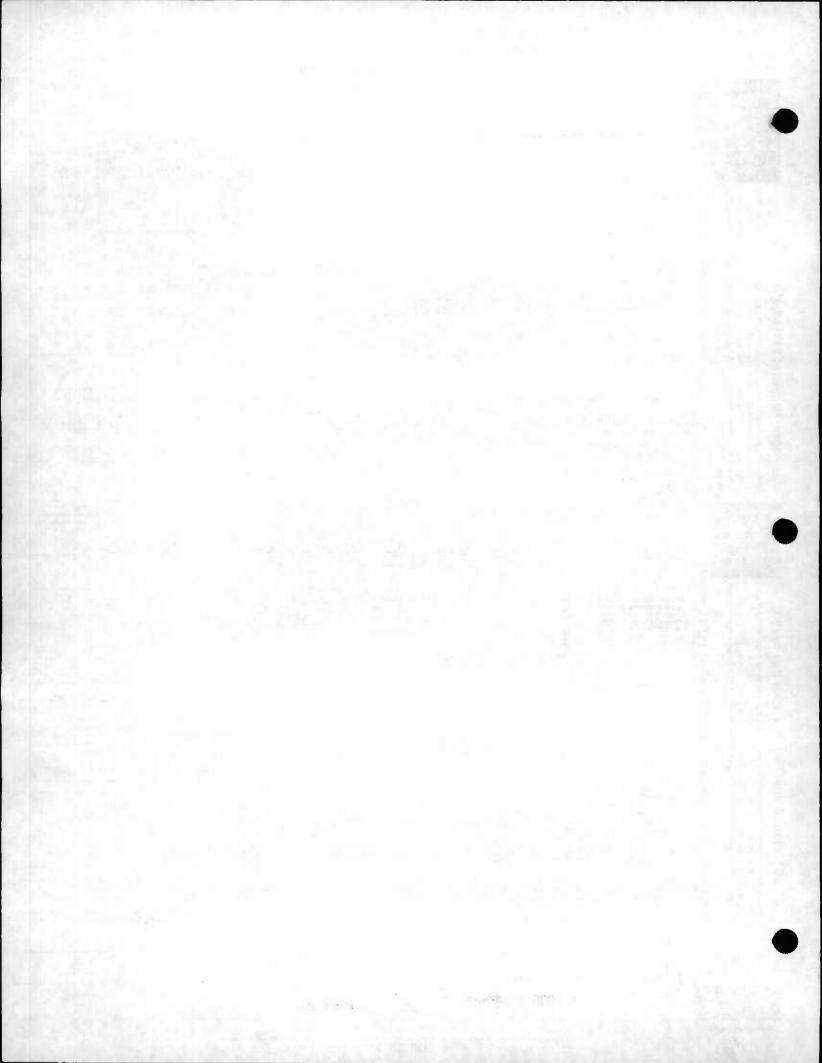
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State of Maryland	Department of H	lealth and Me	ental Hygiene

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vin the Ma t or 28a-1 be notifie Directo	10e. Street and Number	omery	Garthers	10f. Zip Coda			10g. Citizen of	What Country?		
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1 21215-0020 ed within 72 hours at yolene. wer then "natural", or it, the Medical Exam Completed by F	15. Decedant's (Specify only highast of Elamentery/Secondary (0-12)	Education	16a. D	nam 16a. Decedant's Usual Occupation Giva kind of work dona durin lifa. DO NOT use ratired Repair/ Sal		furing most of working		16b. Kind of Businass/Industry Electronics		
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Mary 2 shou 1s mar 1s mar	19a. Informant's Name/Ralationship	(Type, Print)		Aailing Addrass (Street	and Number or Ri	ural Routa Numb	per, City or Town,			
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Ords, P.O. Box 6 requires that the death certificen een signed by the attending it hould be detached for use as sted by Physician/Me	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						23b. Did tobacco use contribute to the cause of death			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

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3. Time of Death

7:25 pm

Birthplace (State or Foreign Country)

WHITE

VA

10d. inside City Limits

Approximate Interval Between Onset and Daath

neeks

1 Yas 2 No

2. Data of Death

30 Pay **Physician** JUNE 2000 WILLIAM HARRISON RAMEY /Medical 4a Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 25131 OLD HUNDRED ROAD DICKERSON MONTGOMERY If Under 24 Hrs. Hours Min. If Under 1 Yaar 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 10 M 2□ F Yrs Director 225-12-2600 NOV 4 Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City, Town or Location ehow. item 27 is marked other than "natural", or itema 23a or 28a-f sho other traumatic avent, the Medical Examiner must be notified at Funeral Director MONTGOMERY MD DICKERSON 10g. Citizen of What Country? 10a. Street and Number 10f. Zip Code 25131 OLD HUNDRED ROAD 20842 U.S.A. death 12. Was Decedent Ever in U,S. Armed Forcas? 1 Dayes 2 □ No if res, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1□ Yes 2 No Specify. Specify: à 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 8 FARMER FARMING 17. Father's Name (First, Middle, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be Department of Health end Mental Important: If Item 27 Is marked of any Injury or other traumatic ava SAMUEL RAMEY ELIZABETH LANG 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 7403 BUNKER HILL RD., HAZEL SISK/NIECE THE PLAINS, VA 20198 20b. Place of Disposition (Neme of cemetery, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata Date Burial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) HYATTSTOWN CEMETERY 7/3 HYATTSTOWN, MD 21. Signature of Fugaral Service License 22. Name and Address of Facility
HILTON FUNERAL HOME BOX 86, BARNESVILLE, 20838 MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one cause on each line. Physician LUNG CANCER Immediate Causa (Final disease or condition rasulting in daath) /Medical Examiner Examiner The lew requires that the death certificate be asscuted the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseasa or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or as a consequenca of) 80 050 P.O. Part ff. Other eignificant conditions contributing to death but not resulting in the underlying causa givan in Part I. 23b. Did tobacco use contribute to the cause of death? be dateched 1 Yee 2 No 3 Probably 4 Winknown Records, þ 24a. Was an autopsy performed? Completed page 2 certificate hes 1 ☐ Yes 2 No of Vital or Attending Physician: 25. Was casa rafarred to medical edicai Certification: To Be 26. Place of Death (Chack only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) After this s after deeth.
I Director: After this of in by the funerel d

28d. Describe how injury occurred

24b. Ware autopsy findings available prior to complation of causa of death?

1 ☐ Yes 2 ☐ No

1 Yes 2 No 27. Manner of Death

1. Decedent's Name (First, Middle, Last)

5 Pending investigation

6 Could not be determined

M.

28a. Date of injury (Month, Dey Year)

28b. Tima of

28c. injury at Work?

1 Yes 2 No 28a. Place of Injury - At home, farm, street, factory, offica building, atc. (Specify)

28f. Location (Streat and Number or Rurel Route Number, City or Town, Steta)

29a. Certifier (Check only one)

1 Natural

2 Accident

3 ☐ Suicide

4 Homicida

JOSEPH

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature and title of certifian

29c. License number

29d. Data signed (Month, Dey, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HAGGERTY MO

JULY 3, 2000

State Registrar

filled in by

completely

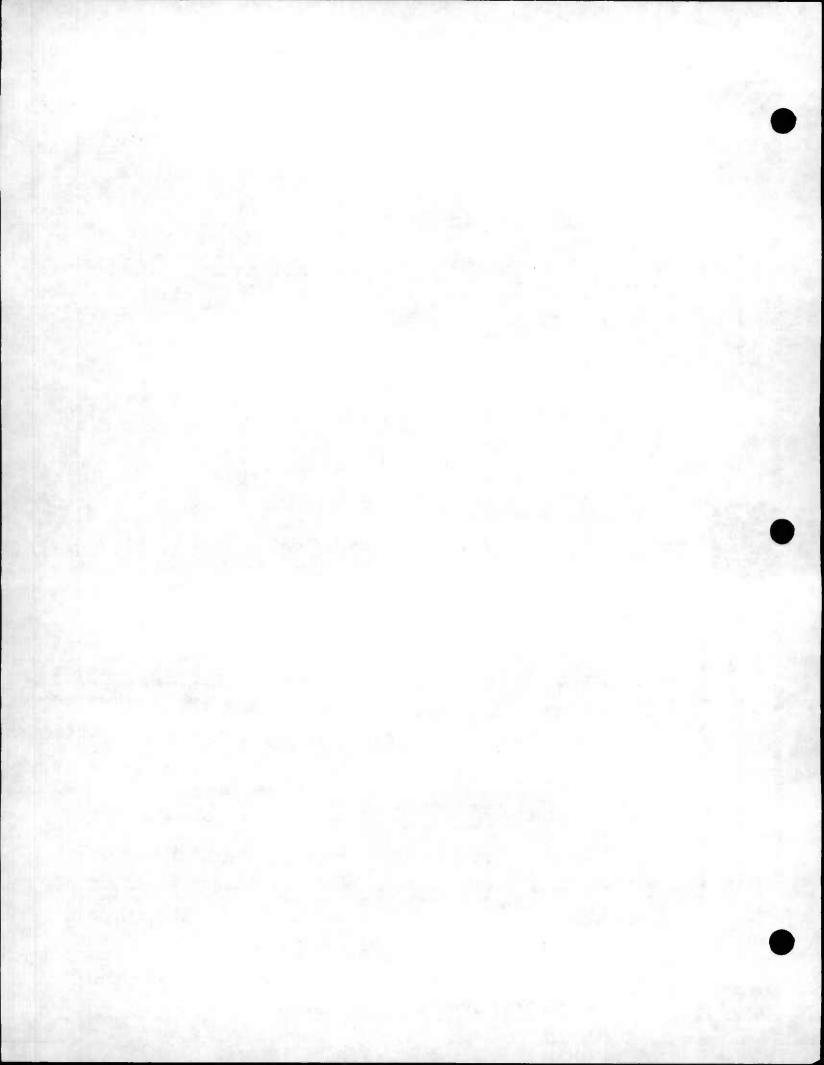
31. Date filed (Month, Dey, Year) 32. Registraria Signatura JUL 2000 ▶

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DHMH 16 Rev 6/95

Division

To the Hospital within 24 hours a



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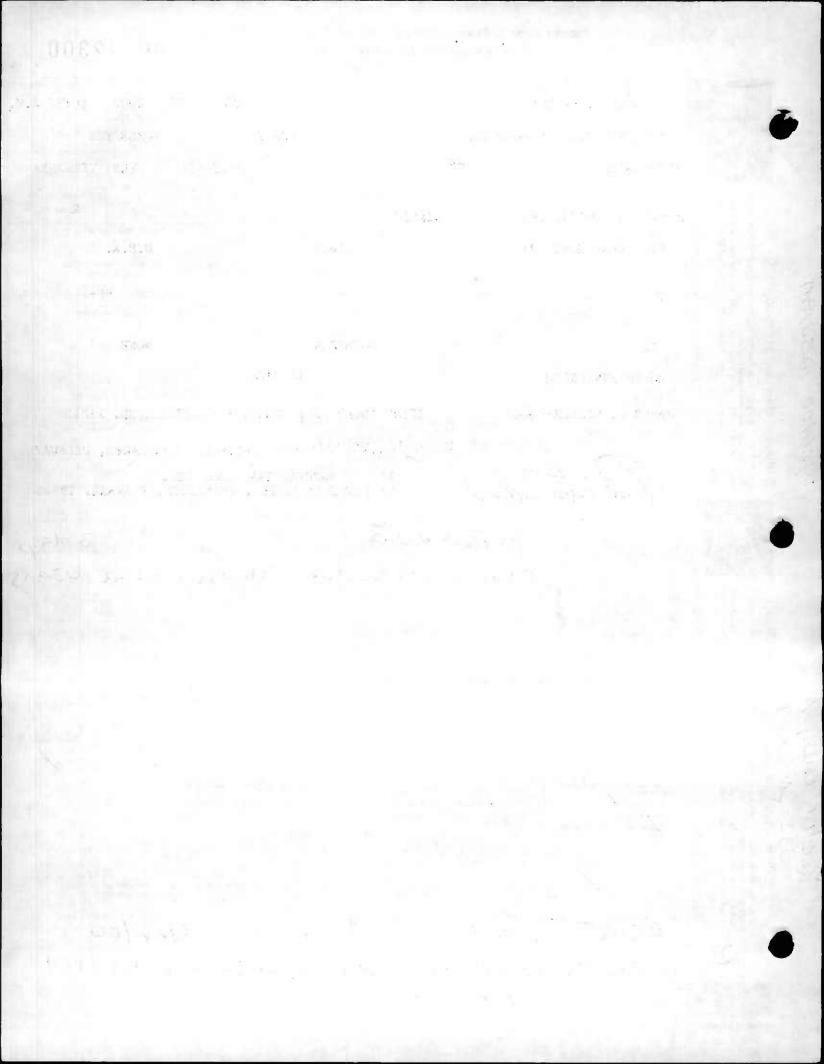
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permit. Pages 1 and 2 should be filed within 72 hours effer death with the Maryland Department of Health and Mentel Hyglene. Important: If Item 27 is marked other than "natural", or Items 23s or 28s-4 show

332 - 30 8 264 Division of Vital Records, P.O. Box 6876

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22301 Certificate of Death Reg. No. 3 Time of Death 1 Decedent's Nama (First Middle Last) 2. Date of Death Year Month **Physician** Orlando Sullivan 17/8 Jerome June 26 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, give street and number) Examiner Pital Heights Prince EMO SINEZ If Under 24 Hrs. 8. Date of Birth Hours Min. Sept. 5, 1929 Wellington, Al. If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 409-42-7469 70 Yrs. Director Usual Residence of Decedent with the Maryland 10d. Insida City Limits 10b. County 10c. City. Town or Location show Item 27 is marked other than "natural", or items 23s or 28s-f show other traumstic event, the Medical Examiner must be nothing at 1 Yes 2 No Director Maryland Prince George's Capitol Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20743 4811 Emo Street United States Funeral death 12. Was Decedent Ever in U,S. Armed Forces? 1 Syes 2 □ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, 11. Maritai Status permit. Pages 1 and 2 should be filed within 72 hours after c. Depertment of Health and Mentel Hygiene. Important: If Item 27 is marked other than "natural, or item any injury or other traumatic event, the Mentel Page 2002. Biack, White, etc. 1 Never Married 2 Married Specify: Black 1 ☐ Yas 2 X No Specify: À 3 Widowed 40 Divorced Completed 16a. Decedant's Usual Occupation 16b. Kind of Businass/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Eiemantary/Secondary (0-12) College (1-4or 5+) Custodial Engineer 11th Nursing Home 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Willa B. Crook John A. Sullivan 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Relationship (Type, Print) 20743 Carlton Sullivan / Brother 4811 Emo Street Capitol Heights, Maryland Place of Disposition (Nama of cemetary, cramatory or other placa) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cramation 3 🔀 Ramovai from Stata 7/1/00 Oaklawn Cemetery Gadsden, Alabama 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility
Alexander S. Pope Funeral Homes 5538 Marlboro Pike/Forestville, Md. 1/085 20747 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Arterioscherette Candisunscular Dis case Immediata Causa (Final diseasa or condition resulting in death) /Medical Examiner Due to (or as a consequence of) Examiner the buriel-transit the death certificete be executed Sequentially list conditions, if any, leading to immediate cause. Entar Underlying Cause (Disaase or Injury that initiated events resulting in daath) Last pue Due to (or as a consequenca of): P.O. Box 68760, the attending physician Physician/Medical Due to (or as a consequence of) Se esn Part II. Other algoriticant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco usa contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed After this certificate hes 1 ☐ Yes 20 No 1 ☐ Yes 2 ☐ No Division of Vital Hospital or Attending Physician: 24 hours efter death. Funeral Director: After this certifice 25. Was case rafarrad to medical examiner? Be 26. Piace of Death (Check only ona) Other: 4 Nursing Home 5 Hesidenca 6 Other (Specify) 0 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Time of 5 Pending invastigation 1- Natural Injury 1 Yes 2 🗌 No 2 Accident 3 Suicide 6 Could not be determined 28e. Piace of Injury - At home, farm, streat, factory, office building, etc. (Specify) 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 ☐ Homicide To the Hospital within 24 hours e To the Funeral C 29a. Certifian 1 Ceptifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the causa(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causa(s) and manner stated. Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and little of certifie

194, DO

3. Ragistrar's Signature

Pital

30. Name and address of person who completed cause of death (item 23a) (Typa, Print)

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State Registrar

31. Data filed (Month, Day

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the local and an in a

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22302 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 22, Annie M. June 2000 8:57am /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Southern Maryland Hospital Clinton Prince George's If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (Stata or Foraign Country) **Funeral** 1□M 2⊠F Months Yrs. 577-14-7131 88 Director March 25, 1912Abbeville, S.C. Usual Residence of Decedent death with the Meryland 10a. State 10c. City, Town or Location 10b. County ahow 10d. Insida City Limits r than "natural", or hama 23s or 28s-f shorth Medical Exercises must be notified at Maryland Prince George's Clinton 1√2 Yas 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9601 Pineview Ln. 20735 United States Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Maxican, Puerto Rican, atc.) 11. Marital Status 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, Black, Whita, atc. filed within 72 hours effer 1 ☐ Yes 2K No If Yes, Give Year or Dates: 1 Never Married 2 Married Baitimore, Maryland 21215-0020 1 Yas 2 No Specify: þ Specify: Black. 3☑ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work dona during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: if item 27 is marked other th eny injury or other traumatic event, this pince. Domestic Engineer Private 17. Father's Nama (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Be James Roebuck Lula M. Robinson 19a. Informant'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 3100 Metronome Turn Clinton, Maryland Harold Smith / Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stete 1 ☐Burial 2 ☐ Cremation 3 ☐ Removal from State 6/29/00 Lincoln Cemetery Suitland, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Fecility Alexander S. Pope Funeral Homes M(085 5538 Marlboro Pike/Forestville, Md. 20747 Approximate Interval Between Onsat and Death 23a. Pert1. Enter the disease or completation, that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrast, shock, or heart feilure. List only one cause on each line. **Physician** Immediete Cause (Finel diseasa or condition rasulting in death) /Medical hemmorshage Examiner Physician/Medical Examiner pertension attending physician and for use es the burial-transit or Attending Physicien: The law requires that the death certificate be assouted Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last e to (or as a consequence of) P.O. Box 68760. Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknown ste has been signed page 2 should be de Records, þ Be Completed 24b. Wara autopsy findings available prior to 24a. Was en eutopsy parformed? complation of causa of death? 1 Yas 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital director. 25. Was case refarred to medical 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Othar (Specify) 1 Yes ≥ No Certification: To 1 ★ Inpetient 2 ER/Outpatient 3 DOA this funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 24 hours effer death. Funerel Director: After 1 Netural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be detarmined 3 Suicide 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Routa Number, City or Town, Steta) filled In by 4 Homicide Hospital 29a, Certifier 150 Certifying Physician: To the best of my knowledge, death occurred et tha tima, data and place, and due to the cause(s) and mannar as statad.
2 Description on the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end place, and due to the ceuse(s) and manner stated. edical within 24 hor To the Fune completely f (Check only To the 29c. License number 29b. Signature and after of certifier 29d. Data signad (Month, Day, Year) run au MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

7801 Old Branch Ave 409 Clinton MD20735

RAHIMIAN MD

37. Registrar's Signature

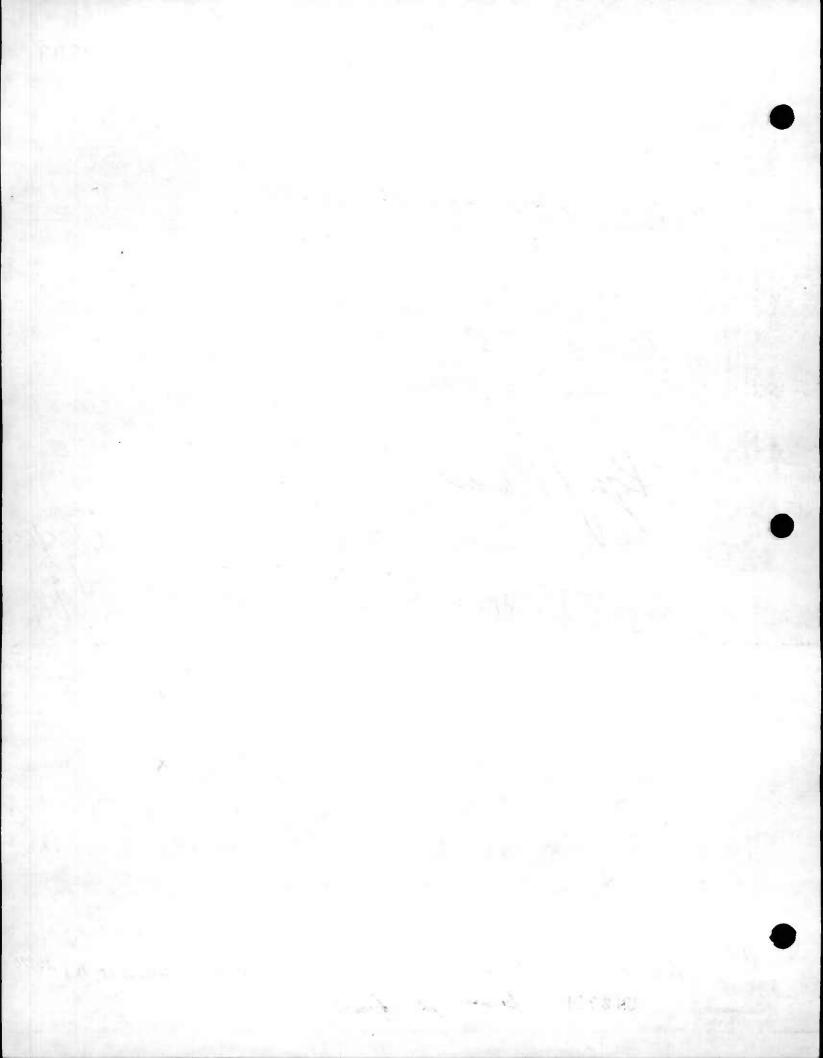
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State of Maryland / Department of Health and Mental Hygiene 00 22303

	Certificate of Death	Reg. No.	0 22303			
Dhusisian	Decedent's Name (First, Middle, Last)	2. Date of Death Month Day	3. Time of Death			
Physician /Medical	Willie Marie Smith	06-24-200				
Examiner		koma Pk 4c. Coun Mon	y of Death tgomery			
Funeral Director	5. Social Security Number 5.77-58-1492 6. Sex 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1 Months 1		9. Birthplace (State or Foreign Country). Washington D			
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E 2 2	10e. Street and Number 14117 Armilla Ct 10f. Zip Code 20866	10g. Citizen o	What Country?			
by FF. 5	11. Marital Status 12. Was Decedent Ever in U,S. Armed Forcas? 13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put If Yes, Give Year or Dates: 14. Was Decedent Ever in U,S. Armed Forcas? 15. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Put If Yes, Give Year or Dates:		ce - American Indian, ack, Whita, atc. 3,1 a c k			
72 hours natural; deal Ex	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of w	16b. Kind of	Business/Industry			
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e, Mar 1 and 2 sho Health and I em 27 le m Wher treum	19a. Informant's Name/Relationship (Type, Print) Michael Smith(SON) 19b. Mailing Addrass (Street and Number or 14117 Armilla Ct					
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Dalling	21. Signature of Fusieral Service Licensee 22. Name and Address of Facility POB 528 Ashland		y Funeral Hom			
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Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death) Cand (ruction	Onset and Death			
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aw requir		24a. Was an autopsy performed?	24b. Wara autopsy findings available prior to completion of causa of death?			
E 6 4 9 5		1 ☐ Yes 2 No	1 ☐ Yes 2 ☐ No			
Physician: The lave this certificate hes ral director, page 2 ral comp	axaminar/	Peath (Check only ona)				
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(10)	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Or . Th. L. Will 7525 Breenway	ctr. Dr. Gre	whelt med 2077			
State Registrar	31. Date filed (Month, Dey, Year) JUN 2 7 2000 32. Registrar's Signatura					

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State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 00 22305

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O Name and address of person who completed cause of deeth (Item 23a) (Type, Print) Peter R. Graze, MD, 900 Bestgate Rd. #300, Annapolis M 31. Date filed (Month, Day, Year) 32. Registrar's Signature	Hospital or 1 24 hours after Funeral Dire stely filled in b	building, etc. (Specify) 29a. Certifier (Chapt on) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de-	City or Town,	State)	tated.	
Peter R. Graze, MD, 900 Bestgate Rd, 7300, Hhnapolis M	within in to the comple	29b. Signature and table procertifier (CO) (M) 29c. License number (D) (G) 3 (C)	e4 290	Date signed (Month,	Day, Year)	
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22306 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth **Physician** June 23, 2000 7:00 P.M Susan Louise Stup /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince Georges 2922 Tallow Lane Bowie Hours Min. 8 Date of Birth (Month, Day, Year) 9. Birthplace (State or F. Country) 3 Wash.D.C. ff Under 1 Year 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months 1□ M 2√2 F Yrs. 227-80-5309 46 Director Usual Residence of Decedent permit. Peges 1 and 2 should be filled within 72 hours effer deeth with the Meryland Department of Health and Mental Hygiene. Important: if them 27 is marked other than "natural", or them 23a ~ ^a~ any Injury or other traumatic event. 10d. Inside City Limits 10a. State 10c. City. Town or Location 1 ☐ Yes 2X No Md. Mitchellville Funeral Director Prince Georges 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10111 Cleary Lane 20721 USA Was Decedent of Hispanic Orlgin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien, Was Decedent Ever In U.S. Armed Forces? 11. Meritel Stetus Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Married 1 Yes 2 XNo Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) William B. Mayhew Marsha Shuey 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Richard P. Stup/Husband 10111 Cleary Lane, Mitchellville, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06-27-00 Alex. Va. Metropolitan Crematory 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Beall 6512 N.W.Crain Hwy., 22. Name end Address of Facility Funeral Home Bowie, Md.20715 Robert G. Beal 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting In death) /Medical CARDIAL HOLEST Examiner Due to (or as a consequence of) Physician/Medicai Examiner The law requires that the death certificate be executed Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequenca of): end buriel-tran Records, P.O. Box 68760, physician the Due to (or as a consequence of) 23b. Did tobacco use contributa to the causa of death? Part ff. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ed by th 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown should be det by 24b. Were autopsy findings eveileble prior to completion of cause ot death? Completed 24a. Was an autopsy 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Dtrs. Medical Certification: To 1 Yes 2 100 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day Year) funeral 27. Maryfer of Death 28c. Injury at Work? 28d. Describe how injury occurred Res. 28b. Time of After 1 Natural 5 Pending 1 Yes 2 No hours after death. investigetion 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral Completely filled Hospital 29a, Certifier Ecritifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name end eddress of person who completed educe of death (Item 23a) (Typa, Print) Green belt, Md. 20770 7500 Coabreil Jaffe Hanover ok

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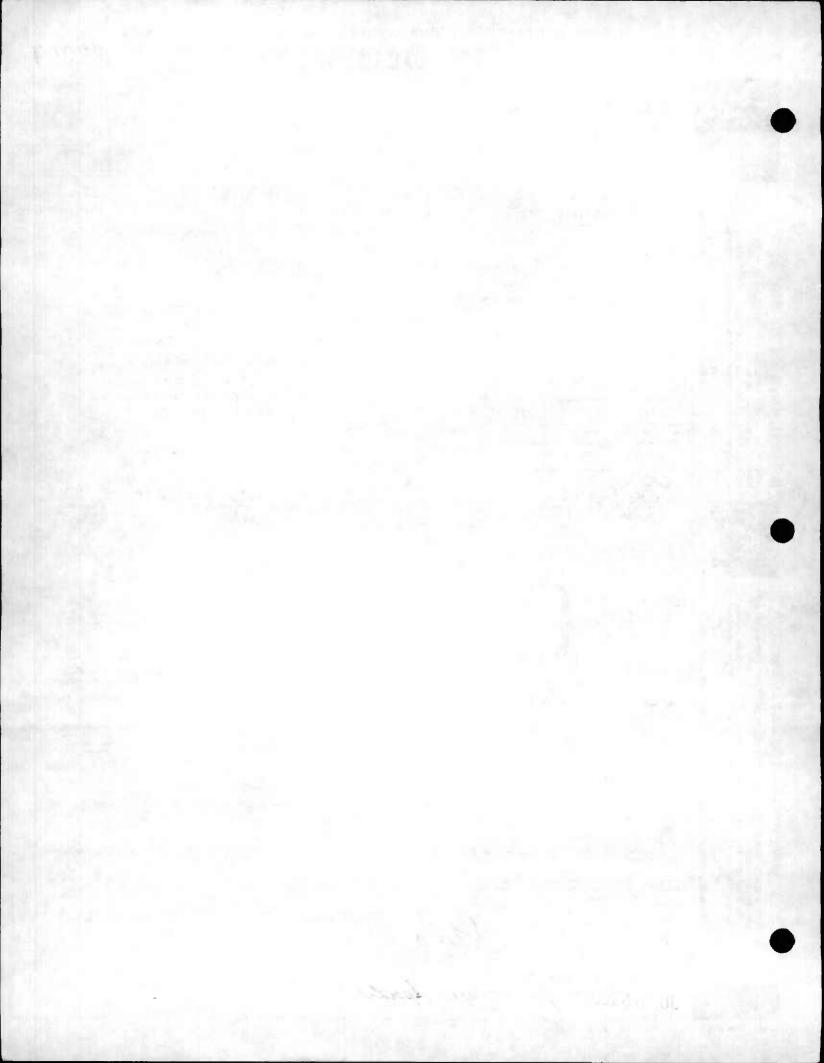
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32 Registrer's Signature

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B.K.S

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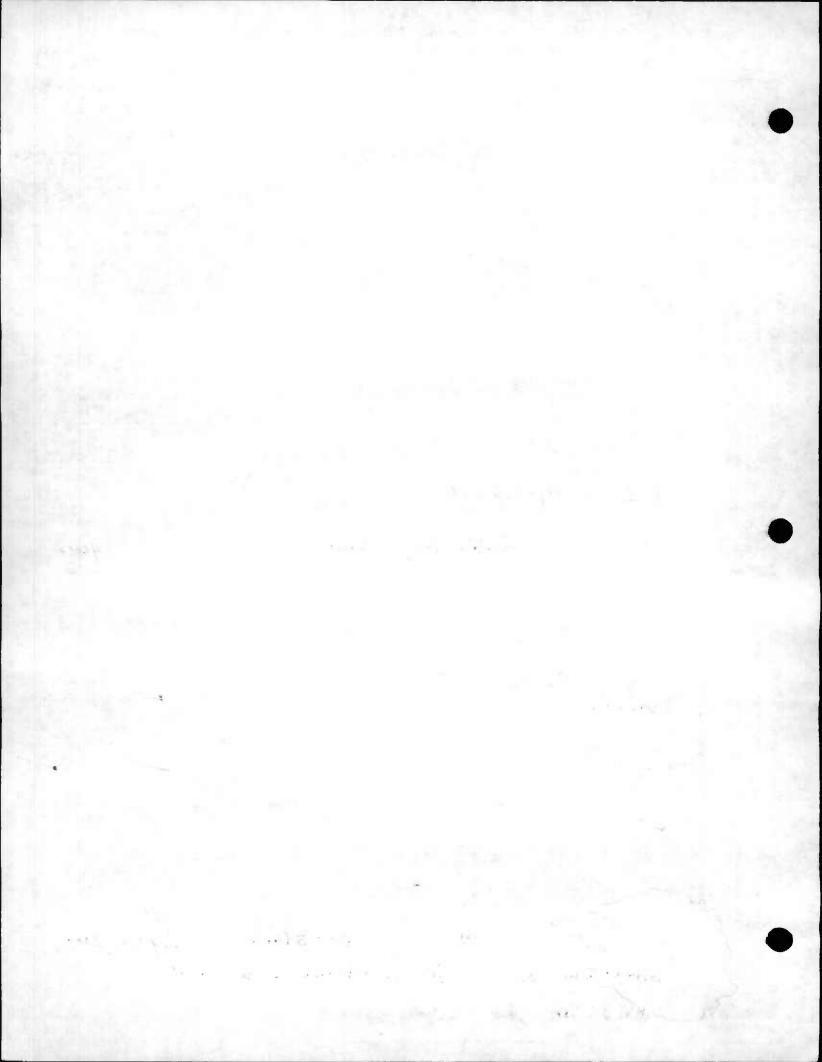
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Š,		Sequentially list conditions, if any, leeding to immediate cause. Enter Undarlying Couse (Disease or Injury that initiated events	c							
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OX P	5 ×		d							
90	d by the attend etached for us Physician/			7/ 7/						
	the day	Pert II. Other significant conditions co	ntributing to death but not res	sulting in the u	nderlying cause gi	ven in Pert I.	23b. Did	tobacco uss co		the cause of death?
5	detay detay	HISTORY OF HYPERTHYR	OIDISM				10	Yss 2 No	3 Pro	bably Munknown
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Meision	as after death. al Director: After tied in by the funer Certification:	4 Homicide determined	building, etc. (Speci	ify)	adi, rodiory, dilloo			wn, Steta)		
7		29e. Certifier 1 ☐ Certifying Phy	sician: To the best of my kno	owledge, daeth	n occurred at the t	me, dete end pl	ece, end due to the	cause(s) end m	annar es s	statad.
1	n 24 hou he Fune pletely fi		iner: On the basis of examine and menner statad.							
	Me Me	29b. Signeture end title of certifier	101		29c. Licen	se number		29d. Date signe	ed (Month,	Dey, Year)
	- 51- 0	//	1/1/		0	.C.M.E.		July 05	5, 20	00
		30. Neme end address of person who co	ompleted cause of death (Ita	m 23a) (Type	Print)					
		D M	utemo			et. Rali	timore, M	arvland	2120	1
	State	31. Day iled (Manth) (Parties)		etura	1	,	LAMOLO F	LL y JURK	~120	-

Registrar



amend item 2	State of Marylar 5 per phys G786 8/31/00 yf	nd / Department of Health and Me Certificate of Death	ental Hygiene 00	22309
Physician	Decedent's Nama (First, Middle, Last)		2. Date of Dealh Month Day Year	3. Time of Death
/Medical	George Albert Savage 4a Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	May 29 2000 cation of Death 4c. County of Dea	
Examiner	Frederick Memorial Hospital	Frederick	Frederic	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. 15 M 2 F 85	last birthday) If Under 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Year) 9. Bir	thplace (State or Foreign ountry)
Dun N	Usual Residenca of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Location		10d. Inside City Limits
V A S the Marylar the Marylar the motified at	Maryland Frederick	Mount Airy		1 ☐ Yes Ž No
Avaganish the Manylar as or 28a-1 show the notified at	10e. Street and Number	10f. Zip Code	10g. Cifizen of What Co	ounfry?
SAVAS death with the Manyland of mas 23a or 28a-f show traum be notified at meral Director	6149 Detrick Road	21771	U.S.A	
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2 hours	15. Decedent's Education	16a. Decedent's Usual Occupation	16b. Kind of Business	
21215-0 121215-0 ed within 72 ho yglene. or the wester it, the Medical	(Specify only highest grada completed) Elementary/Secondary (0-12) College (1-4or 5+)	(Give kind of work done during most of working life. DO NOT use retired)		1
D PER D	8 17. Father's Nama (First, Middle, Last)	Farmer 18. Mother's Name	(First, Middle, Maiden Sumame)	
yland yland wental H erked oth attc even	Harry Randolph Savage	Osie	Bertha Poole	9 5
A S B E E	19a. informant's Name/Relationship (Type, Print)	19b. Meiling Address (Street and Number or Rura		
re, N st land is st land is st health item 27 other tr	Doris Larue Savage - Wife 20a. Method of Disposition 20b.	6149 Detrick Road, Mour	nt Airy, Maryland Date 20c. Location - Cify or	
0 0 0 7 7	1 Burial 2 Cremation 3 Removal from State	carnetery, crematory or other place)		
Baltim pemir. Peg Department Important: I any Injury o	21. Signalure of Funeral Service Licensea	22. Nama and Addrass of Facility		all will be to be a first
B E G G G G G G G G G G G G G G G G G G	Olivi I. Molesworth	Olin L. Molesworth 26401 Ridge Road,		
	23a. Part1. Enter the diseese, or complications that caused the deal shock, or heart failure. List only one cause on each line.	h. Do not enter the mode of dying, such as cardiac or	respiratory arrest,	Approximate Interval Between Onset and Death
Physician /Medical Examiner		Pegaghania or as a consequence of):		yews
si si si si si si si si si si si si si s	b			
8760, ata be executed hysician and the buriel-transit dical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury c.	or as a consequence of):		
S, P.O. Box 68760 as that the death certificata be a greed by the attending physician be detached for use as the burit by Physician/Medical E		or as a consequenca of):		
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P.O nat the day the setacher	Dementin		1 Yes 2 10 3 P	Probably 4 Unknown
on of Vital Records, P.O. Box 6. Ang Physician: The law requires that the death certificate has been signed by the attending prineral director, page 2 should be detached for use as flon: To Be Completed by Physician/Median:			24a. Was an autopsy performed?	Were autopsy findings available prior to complation of causa
Re he lav			1 Yes 2 No	of death?
Vital Indian: The certificate rector, pag	25. Was case referred to medical examiner?	26. Place of Death		
hyale hyale or il direct	1 Yas 2 No Hospital: 1 Inpatient 2		ne 5 Residenca 6 Other (Spe	scify)
- B 95 E	27. Menner of Death 1 @Matural 5 Pending (Month, Day Year)	28b. Time of lnjury at Work? M 1 Yes 2 No	28d. Describe how injury occurred	
Division of Vita To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completally filled in by the funeral director.	2 Cuiside 6 Could not be	ome, farm, street, factory, office	28f. Location (Street and Number or F City or Town, State)	Rural Routa Number,
DivI To the Hospital or Att within 24 hours affect completely filled in by Medical Certiff		owledge, deeth occurred et the time, date end plece, e tion and/or investigation, in my opinion, deeth occurre		
To the within To the comple	29b. Signature and WHS of cediller	29c. License number	29d. Date signed (Mon	nth, Dey, Year)
	5 Som ws	00054616	May 31	2000
	30. Name and address of person who completed cause of death (Iter SHALL 318 CL	m 23e) (Type, Print) K. St. Franke M.	0 21701	
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrer's Signification of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of the State of th	style Leaster		

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hysician /Medical	WILLIAM A. SUTHERLAND			Month June	Dey Yeer 25 2000	8:35 P
xaminer	e Facility Name (If not institution, give street and number)	45 ATT - 15TE	4b. City, Town, or Location		4c. County of Dea	
	Genesis ElderCare - The F	Pines	Easton		Talbo	ot
eral	i. Social Security Number 6. Sex 7. Age (In yr.	s. last birthday) If Under 1 Y	ear If Under 24 Hrs. 8.	Date of Birth (Month, Day,		thplece (State or Fore
tor	214-34-6061 ¹ ∑ ^M ^{2□ F} 63	Yrs.	J	AN. 21	, 1937 MAI	RYLAND
	Jsuel Residence of Decedent 10a. Stele 10b. County 10c. C	City, Town or Location				10d Incide City Lim
rector		EASTON				10d. Inside City Lim 1 N Yes 2 □ I
Director	110					
5	0e. Street and Number	10f. Zip Co		10	g. Citizen of Whet Co	ountry?
by Funeral	610 DUTCHMANS LANE	216			USA 14. Race - Ame	rices Indias
S	11. Meritel Stetus 1 ☐ Never Merried 2 ☐ Married 12. Wes Decedent Ever in Armed Forces? 1 ☐ Never Merried 2 ☐ Married	If Yes, specify	of Hispanic Origin? (Specify Cuban, Mexicen, Puerto Rice	an, etc.)	Bleck, Whit	
by	3 Nidowed 4 □ Divorced Yeer or Deles:	1 □ Yes 2 🔀	No Specify:		Specify: W	HITE
	15. Decedent's Education	16a. Decedent's Usuel O	ccupation	1	6b. Kind of Business	/Industry
Completed	(Specify only highest grede completed)	(Give kind of work de life. DO NOT use re	one during most of working ottred)			,
E	Elementary/Secondery (0-12) College (1-4or 5+)	PAINTER		H	OME IMPRO	VEMENT
BeC	7. Father's Name (First, Middle, Last)		18. Mother's Neme (Fi	irst, Middle, M	aiden Sumeme)	
To B	WILLIAM R. SUTHERLAND		LILLIAN L.	MILLE	R	
-	19e. Informent's Neme/Reletionship (Type, Print)	19b. Meiling Address (St	reet end Number or Rural Ro	oute Number,	City or Town, Stete,	Zip Code)
To Be C	DEBBIE A. BUCKLE/DAUGHTER	5017 MT. ZIO	N RD HURLOCK,	MD 21	643	
		. Plece of Disposition (Neme of	/D	Dete 2	Oc. Location - City or	Town, Stata
	1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify)	cemetery, cremetory or other HESAPEAKE CREM		26-00 9	TEVENSUIT	LE MD
	21. Signeture of Funeral Service Licensee	OO Nome and A	ddaga of Carilla			**
poce.	Joseph M. Ostrowsky	FELLOWS	HELFENBEIN &			
	23e. Pert1. Enter the disease, or complications that caused the de shock, or heart failure. List only one cause on each line.		HARRISON ST.			Approximete Intervel Between
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2 should be d pleted by	Athero sclerotio Cardiore	escular disc	ase	24e. Wes en perform	ed?	Were autopsy findin available prior to completion of cause of death?
oral director, page 2 s 1: To Be Comple			ATTENDED TO	1 ☐ Yes	s 2XNo	1 ☐ Yes 2 ☐ No
BeC	25. Wes case referred to medical		26. Place of Death (C	heck only one		
ToB	examiner? 1 Yes 2 No Hospitel: 1 Inpatient 2	□ ER/Outpatient 3□ DOA	0		nce 8 Other (Spe	ocify)
atlon:	77. Menner of Death 1 Neturel 5 Pending 2 Accident Accident Accident 28e. Dete of Injury (Month, Dey Year)	28b. Time of 28c.			w injury occurred	
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	me Ino		ソレフソフノ		6.26.0	30
State	No. Neme and address of person who completed cause of death (Ite MICHALL CROWLLY MD 51. Dete filed (Month, Dey, Year) 32. Registrer's Sign JUN 2 6 2000	508 IDWWI	D AVENUE	F	ASTON, M	10 2180

SHS

State of Maryland / Department of Health and Mental Hygiene 00 22311

			Ce	ertificate o	f Death		Re	g. No.	, ,	2011.
Physicia	1. Decedent's Nama (First, Middla, L.	est)				2.	Deta of Death Month		Yaar	3. Tima of Death
/Medica	DONALD			STEWAR	r .	JU		,2000	raa	16:40pm
Examine	4e Facility Nama (If not institution, gi					own, or Locati		4c. County of	f Death	
193	Calvert Memoria		<u> </u>	- Milladas d Ma		ce Fre	derick	(Calve	
Funeral Director	217-28-1840	Sex YOM 2□F	(In yrs. last birthda) 67 Yrs.	Months Day		24 Hrs. 8. Min. O	Data of Birth (Month, Day, ct. 14,	Year) 1932	9. Birthpli Count Ma1	aca (Stata or Foreign ry) cyland
pue **	Usual Residence of Decedent 10a. Stata 10b. County		10c. City, Town or I	Location					10	d. Inside City Limits
Sa-f aho	Maryland Calver	t	Hui	ntingtown						1 ☐ Yas 2 ☒ No
deeth with the Meryland me 23e or 28e-f ahow rment be notthed at	Maryland Calver 10e. Street and Number 1710 Kings Landi 11. Marital Status 1 Never Married 2 (X Married	ng Road		10f. Zip Code 20	639		10	g. Citizen of Wi USA	nat Count	ry?
ather or the	3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ev Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	rer in U,S. 13	Wes Decedent of If Yes, specify C			y Yes or No- an, atc.)	14. Race Black, Specify:	White, e	tc.
100 c 1 2 c	15. Decedent's E (Specify only highest gr	ducation ade completed) College (1-4or 5+	(Giv	edent's Usual Occ re kind of work doi DO NOT use ret arpenter	cupation ne during mos ired)	st of working	1	6b. Kind of Bus		
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e, Mary	19a. Informant's Name/Relationship Betty Stewart/Wif			ling Address (Stre Kings La						
Baltimore, Nomit. Peges 1 and Department of Heelth Important: If Item 27 and Into Juny or other to and and and and and and and and and and	20a. Method of Disposition 1 ②Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Speci			position (Name of ematory or other p		7/1		Oc. Location - C		vn, Steta
Baltimopemir. Peg Department Important: Inspectant: In	21. Signature of Funeral Service Lice			22. Nama and Add	fress of Facili	sewe:	11 Fune	ral Hon	ne	
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The lew ate has b paga 2 s							1 Yas	2 M No		Yes 2 No
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3	30. Nama and addrass of person who	completed cause of dea		, Print)	н	UNTIN	GTOWN	MARY	LANI	20639
State Registrar	31. Data filed (Month, Day, Year) JUN 3 (32. Registrar		B. Sp						

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State of Maryland / Department of Health and Mental Hygiene 11 22312

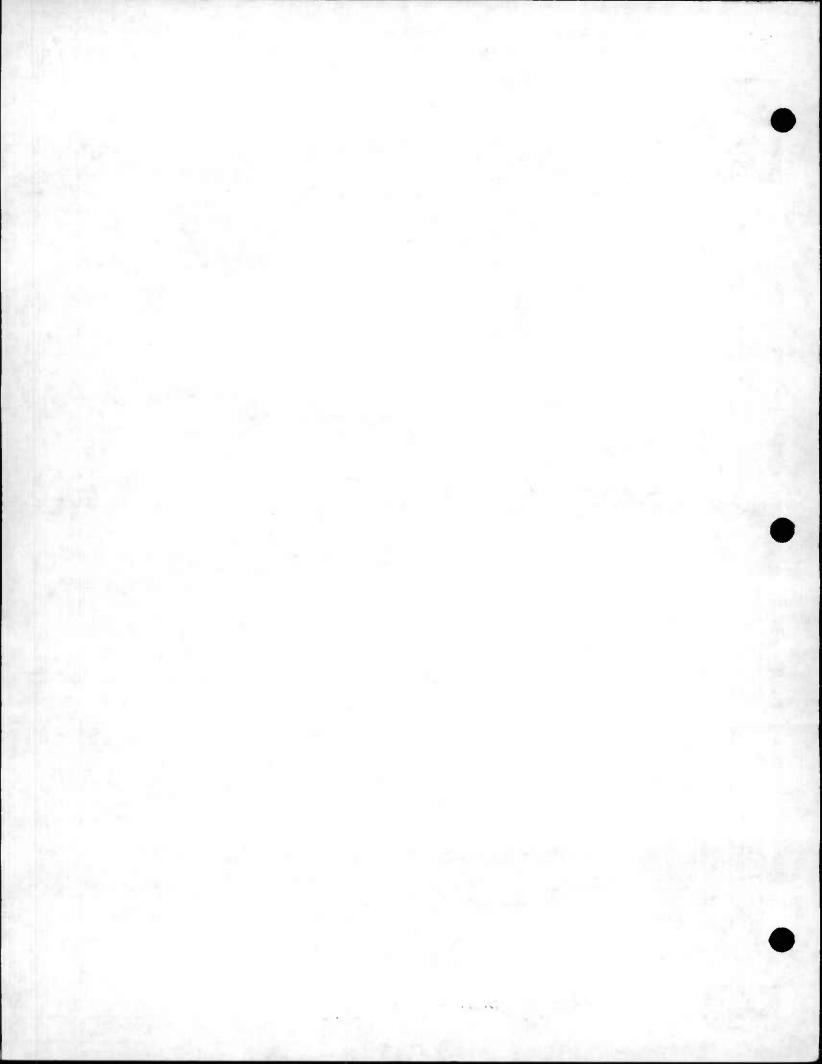
			C	ertificate of	Death		Reg. No.	44016
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。/Medical Examiner	4e Facility Name (If not institution, g Washington Co		tal			or Location of Deeth	4c. County o	
Funeral Director	213-12-9179	Sex 7. Age (fr	yrs. lest birthde 77 Yrs.	y) If Under 1 Yaar Months Days		lin. 8. Date of Birt (Month, De Dec 1	1,1922	9. Birthplece (Stata or Foraign Country) Maryland
Meryland H show fred at	Usual Residence of Decedent 10e. State 10b. County MD Washi	ngton 10	c. City, Town or Hagerst					10d. Inside City Limits 11 Yes 2 □ No
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ed within 72 ho ygiene. In the Hedical It, the Hedical	15. Decedent's (Specify only highest s Elementery/Secondery (0-12)	rede completed)	16a. Dec (Gi	cedent's Usual Occup ve kind of work done . DO NOT use retire	pation during most of a d)	working	16b. Kind of Bus	
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A P S M	Courtney A. Flet			42 65		M. Adams		
aith and Mer 27 is marke r traumatic	19e. Informant's Name/Raletionship Harry L. Salvato			iling Address (Street Kenwood D				
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Depertm Depertm Importer any Inju	21. Signature of Funeral Service Lic	Zinne	I	22. Name and Addre Douglas A. 1331 Easte	Fierv	Funeral H	lome erstown,M	aryland 21742
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cartificate has rector, paga 2						10		1 ☐ Yes 2 ☐ No
big DI	25. Was case referred to medical examiner? 1 Yes 2 No 27. Menner Death 1 Deatural 5 Pending	Hospitel: 1 Inpatient 28a. Date of Injury (Month, Dey Ye	ER/Outpat 28b. Time Injury	of 28c. Inju	her: 4 Nursing ry et rk?	Death (Check only of Beside 1986). Describe I	water to be a series	
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	30. Nama and address of person wh	o completed causa of deeth	(Item 23a) (Typ	# 130	Ithe	ERITOW	W. M.)
State	31. Date filed (Month, Day, Year)	2000 32. Registre s	Signature	Loon	6		1	

Salvabore, Mary

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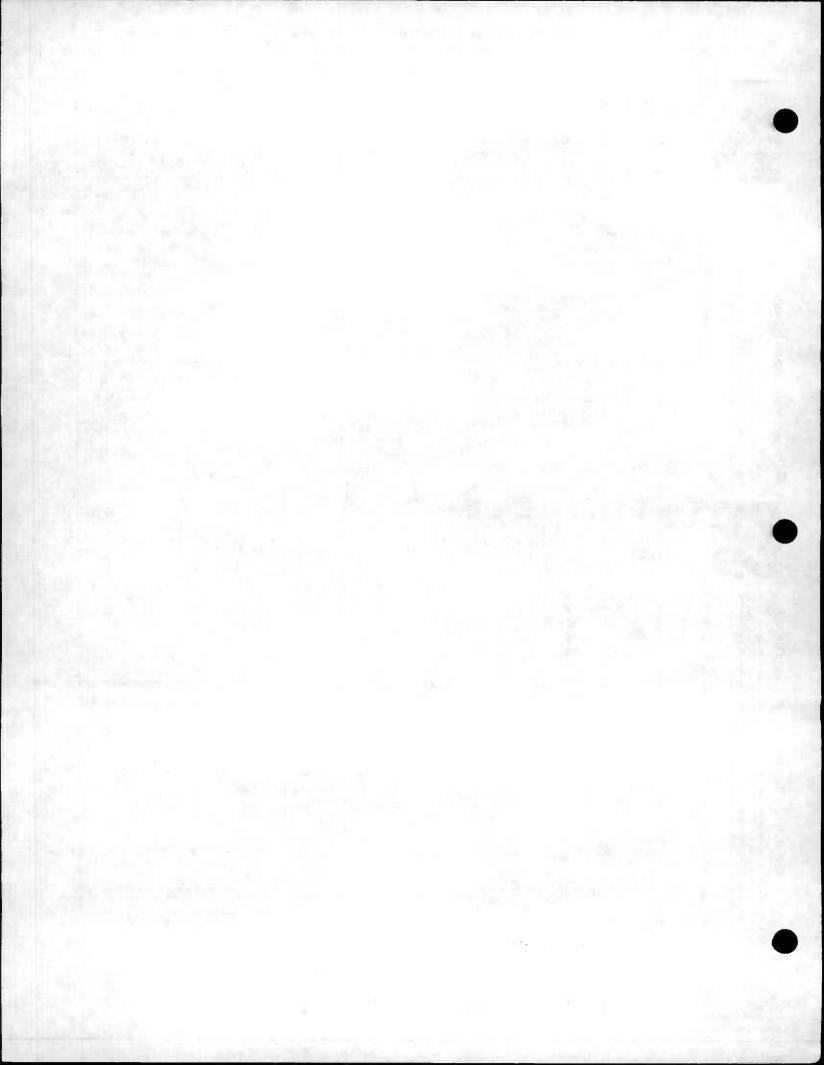
State of Maryland / Department of Health and Mental Hygiene 00 22313

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Examiner	4a Facility Nemo	a (If not institution, gi	va street and number)				4b. City, To	wn, or Loc	ation of Deeth	4c. County	of Death	
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State of Maryland / Department of Health and Mental Hygiene 00 22314

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- 3	1.1	Decedent's Name	,,	Laisi)										3. Time or Deat
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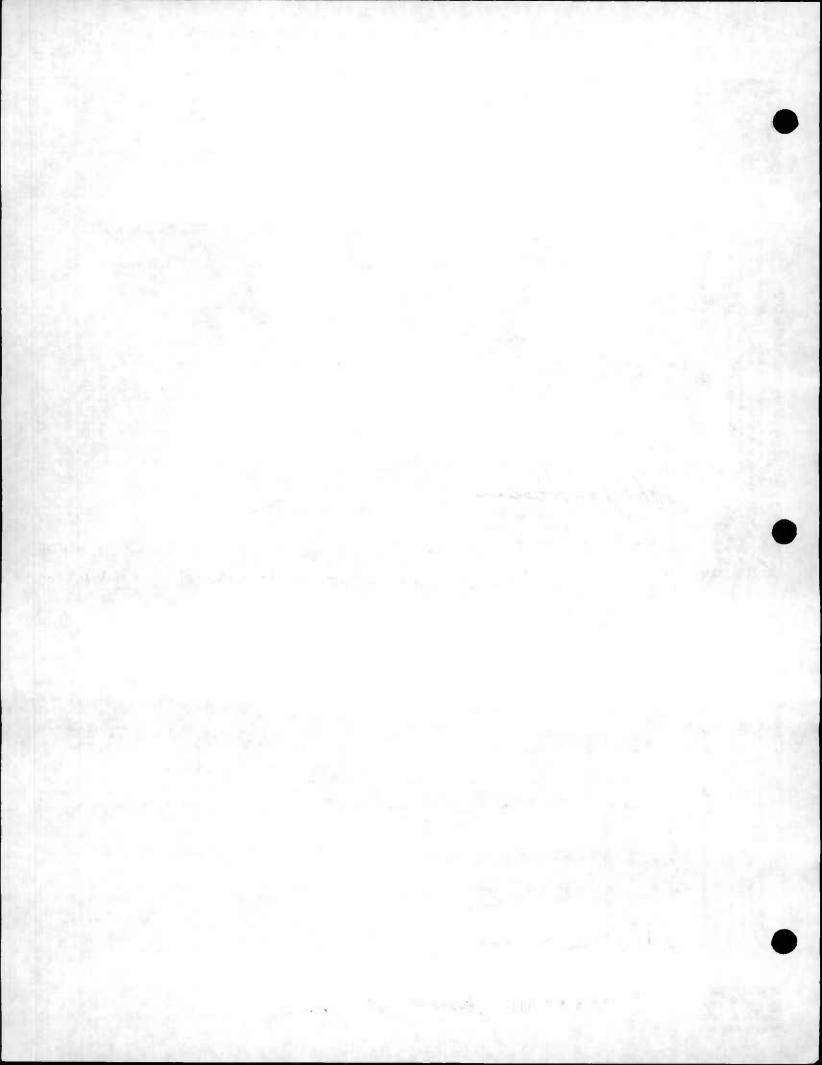


State of Maryland / Department of Health and Mental Hygiene

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State of Maryland / Department of Health and Mental Hygiene 0 0 223 | 6

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iñer	4a Facility Name (If not institution	, giva street and n	um <i>ber)</i>			4		Location of Deat	h 4c. Cou	nty of Death	
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1	5. Social Security Number	6. Sex	7. Age (In y	rs. last birthday	/) If Under 1	Yeer Days	If Undar 24 Hr		th V Year	9. Birth	pleca (Stata or Fora
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3	resulting in death) Last	d									
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	Certificate of Death 1. Decedent's Name (First, Middle, Last)		00 22317
Physicia /Medica	RALPH LEE SPARROW. SR.	Month Day 6 20	2000 8:30 AM
Examine			ounty of Death Drcester
Funeral Director	5. Social Security Number 216-38-3750 6. Sex 1 XM 2 F 59 Yrs. last birthday) Montha Daya Hours	er 24 Hrs. 8. Date of Birth	9. Birthplace (State or Foreign Country) MD
Maryland H ahow	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Ocean City		10d. Inside City Limits 1 M Yes 2 □ No
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2 sho	19a. Informent'a Name/Relationship (Type, Print) 19b. Mailing Address (Street and Num		own, State, Zip Code)
Dalumore, n pemit. Pages 1 and Department of Health Important: If New 27 any Injury or other to	20a. Method of Disposition 1 Burial 2 Connection 3 Removal from State 4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) Cape Henlopen Crematory		ankford, DE
Denti. Departminents any injure.	21. Signature of Juneral Service Licensee 22. Name and Address of Fac	bui bage i unei	al Home 811
Physician /Medical Examiner	23a. Part. Enther disease, or complications that caused the death. Do not enter the mode of dying, such a shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) A Metastatic Colon CA	as cardiac or respiratory arrest,	Approximate Interval Between Onset and Deeth
	Due to (or as a consequence of):		
tificate be executed tificate be executed go physician and es the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		
death ce	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part	t I. 23b. Did tobacco ue	e contribute to the cause of death?
		1 Yes 2	No 3 Probably 4 X Unknow
he lew requires has been sign tge 2 should be		24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?
- F 54 2		1 ☐ Yes 2 🛣 N	No 1 ☐ Yes 2 ☑ No
		ce of Deeth (Check only one) Nursing Home 5 Residence 6	Other (Specify)
Attending Physic death.		28d. Describe how injury o	
5455	3 Suicide 4 Homicide 3 Suicide 4 Homicide 4 Homicide 4 See. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (Street and N City or Town, State)	lumber or Rural Route Number,
he Hospital in 24 hours he Funeral pletely filled	29a. Certifier (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one) (Check only one)	end plece, end due to the cause(s) en eath occurred at the time, date and pl	d menner as stated. ace, end due to the cause(a)
	296. Signature and title of certifier H0053714	- 1	igned (Month, Day, Year)
10+1	30. Name and address of person who completes cause of death (Item 23a) (Type, Print) Jeffrey Matzoni, DO 9714 Healthway Dr. Berl	in, MD 21811	
State Registrar	A CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF		

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 2000 3. Time of Death Month **Physician** Year WILLIAM E. SAVAGE 06/16/00 8:00 am /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth **Examiner** Dorchester Cambridge Mallard Bay Care Center If Under 1 Year if Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days 1₩ M 2□ F Director 213-24-4703 Usual Residenca of Decedent 03/04/25 VA 10a. State 10b. County 10c. City, Town or Location show 10d, inside City Limits traumatic event, the Medical Examiner rount be notified at Director yH⊋ Yes 2 No 28a-f Accomack Atlantic 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 itеms 23a 32333 Wishart Point Road 23303 USA Funeral 12. Wes Decadent Ever in U,S. Armed Forces? Was Decadent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Biack, White, etc. 1 Types 2 No
If Yes, Give
Year or Dates: 146 - 145 1 ☐ Never Merried 2 ☐ Married "natural", or Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 □ Widowed 4 □ Divorced **Black** Completed 15. Decadent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondery (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygiene, Important: If from 27 is marked other the any injury or other fraumatic event, If a page. 4th Laborer Seafood 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Levin Brown Ardonia Watson 2 19a. informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 111, Atlantic, VA Ovie Williams/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 15 Burial 2 ☐ Cremation 3 ☐ Ru 4 ☐ Donation 5 ☐ Other (\$60cl/y)/ 3 DRemoval from State 6/24/00 Atlantic, VA Taylor Cemetery 21 Signature of Funeral Se 22. Name and Address of Facility COOPER & HUMBLES FUNERAL CO., INC. P. O. Box 176, Accomac, VA 23301.

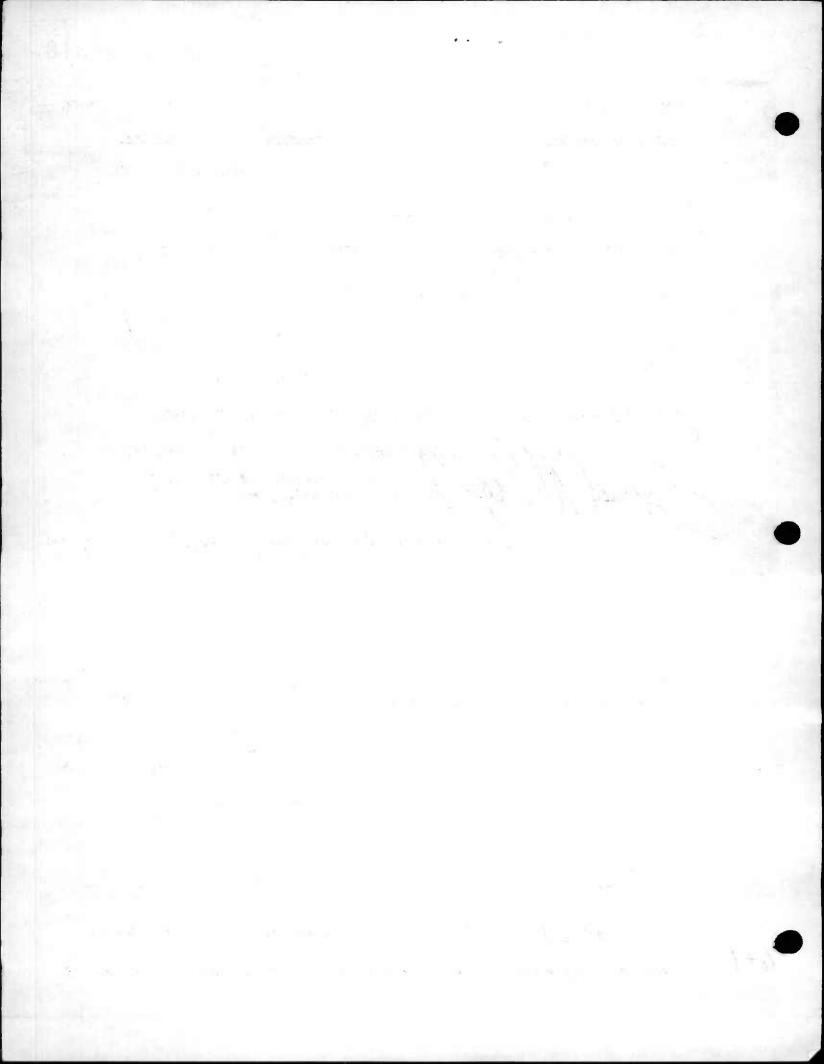
Do not enter the mode of dying, such as cardiac or respiratory arrest, fred the de Approximate Intervel Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical Peripheral Severe Vascular Discose Don Examiner Due to (or as a consequence of): Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or in)ury that initiated events Due to (or es e consequenca of): Records, P.O. Box 68760, The law requires that the death certificate be 4 Due to (or as a consequence of) resulting in deeth) Last 88 esn ò Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Malubition Dementia þ 24b. Were autopsy findings evellebie prior to completion of cause of deeth? Be Completed 24a. Was en eutopsy page 2 s certificate has 1 ☐ Yes 2 No 1 ☐ Yes 2 🗫 Division of Vital Fo the Hospital or Attending Physician: within 24 hours effer death. director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Perursing Home 5 Residenca 6 Other (Specify) 2 1 ☐ Yes 2 ☐NO 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this funeral 27. Manner of Deeth 28a. Date of injury (Month, Day Year) 28c. injury at Work? 28b. Time of 28d. Describe how injury occurred Medical Certification: After 5 Pending investigation 1 Naturel 1 ☐ Yes 2 ☐ No 2 Accident Director: / 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funeral Di completely filled in 29a. Certifier **Certifying Physician: To the best of my knowledge, death occurred et the time, date end plece, end due to the ceuse(s) and manner as steted.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred et the time, date end place, and due to the ceuse(s) and menner stated. 29c. License number 29d. Date signed (Month, Day, Year) MI 6-16-00 D 47924 30. Name and address of person who completed cause of death (item 23a) (Type, Print) NOMAN THANKY 300 AURORA CAMBRIDGE MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

JUN 2 3

Deneros.



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 0 223 | 9

Certificate of Death

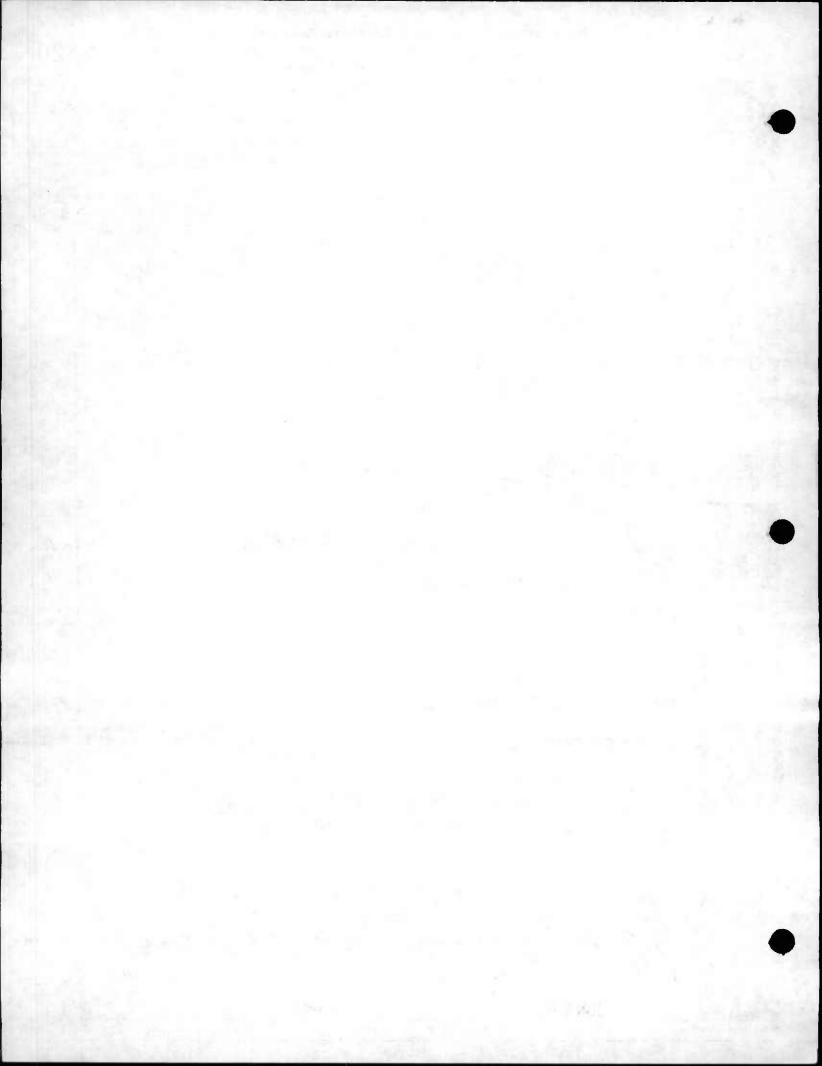
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niner		wn, or Location of De		
		imore, M		timore Ci
al	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff Under 1 Year ff Under 2 Months Deys Hours	Min. 8. Date of (Month,	Birth Day, Year)	Birthplace (State o Country)
or	577-70-0110	2-8-		Wash., D.
	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside Cit
rai Director	10a. State 10b. County 10c. City, Town or Location			1 XYes
ct	MD. Prince Georges Landover			1177162
Director	10e. Street and Number 10f. Zip Code		10g. Citizen of \	What Country?
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by	3 ☐ Widowed 4 🛣 Divorced If Yes, Give Yeer or Detes:		Specify	Black
8	15. Decedent's Education 16a. Decedent's Usual Occupation		16b. Kind of B	usiness/Industry
Completed	(Specify only highest grade completed) (Give kind of work done during most life. DO NOT use retired)	of working		K (200 - 3
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Director	Usual Residence of Decedent		72			July	10,1907	Virgi	шта
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end 2 seith a n 27 is	Lavonya Thomps	son /Grand d	aughter	620 Gre	enwood A	ve., Camb	ridon Ma	rvland	21613
of Health item 27 i	20e. Method of Disposition		20b. Plece of	Disposition (Name	of	Dete	20c. Location		
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The law requires that the death of the last been signed by the attent page 2 should be deteched for us Completed by Physician						11	Yes 2₩No	10	Yes 2□ No
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To the Hospital or Attending Pl within 24 hours efter death. To the Funeral Director: After th completely filled in by the funera Medical Certification:									
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	multo	elelle	ا	1	763	88	JUNE	- 22	,20
	30. Name and edgress of person	who completed cause of	deeth (Item 23e) (Type, Print)			11		
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aminer	4a Facility Name (If not Institution, give	street end number)		PW II	4b. C	ty, Town, or l	ocation of Death	4c. County of	of Death		
	3450 TOLEDO TERRA	CE APARIMEN	Г 617			YATTSV.	ILLE	PRINCE	E GEORGE'S		
eral tor	212-39-6087	7. Age (In XIM 2□ F	yrs. last birthday,	Months		Jnder 24 Hrs. ours Min.	8. Date of Birth (Month, Day Februar		 Birthplace (State or Foreign Country) Ethiopia, East Af 		
	Usual Residence of Decedent 10a, State 10b, County	10	c. City, Town or L	ocation					10d. Inside City Limits		
5									1⊠ Yes 2□ No		
Director	Maryland Prince Ge	eorge's	Hyattsv	1	0.4						
ā	10e. Street and Number 3450 Toledo Terr	775 Ant #6	17	10f. Zip	782			l0g. Citizen of W			
era	11. Marital Status	12. Wes Decedent Ever				ole Origin? (S			, East Africa		
Completed by Funeral	t ☐ Never Married 2 🔯 Merried 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 No If Yes, Give Yeer or Detes:	10.0		ify Cuban, M		pecify Yes or No- Rican, etc.)	Black	Black		
ted	15. Decedent's Edu (Specify only highest grad	cation	16a. Dece	dent's Usual	l Occupation	a most of war	kina	16b. Kind of Bu	siness/Industry		
nple	Eiementary/Secondary (0-12)	College (1-4or 5+)				g most of wor	Na iy	Davison			
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Be	17. Father's Name (First, Middle, Last)						ne (First, Middle,	Meiden Sumeme	9)		
10	Tuaffe Atrea					Zewdiu	Ayele				
	19a. Informant's Name/Relationship (7			-			ral Route Numbe				
	Yetemwork Teferra	a/Wife	3450	Toled	o Ter	race,	#617, Hy	attsvil:	Le, MD 20782		
	20a. Method of Disposition 1 X Burial 2 Cremation 3 1 4 Donation 5 Other (Specify,	Domoval from State	Pob. Place of Disp cemetery, cre Fort Li	metory or of	ther plece)	etery	06/26 2000		City or Town, State Maryland		
any Injury or other traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	21. Signature of Funeral Service Licens	Percentie	. 2 J	2. Name and 5. B. 4 7474 L	Address of JENKIN andove	Facility S FUNE r Road	RAL HOME				
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only	lications that caused the							Approximate Interval Between		
al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	to (or as a conse								
n/Medical	Cause (Disease of highly that initiated events resulting in death) Last Due to (or as a consequence of):							Jal.			
lcia	Part II. Other elgoificent conditions co	ntributing to death but no	at reculting in the	anderlying of	auce given in	Part f	23h Did t	ohacco use con	tributs to the cause of death		
by Physician/	Tartin Strat algument Containors	ntributing to death but not resulting in the underlying cause given in P					1 Yes 2 No 3 Prot		3 □ Probably 4 □ Unknow		
Completed b		F. E.					24e. Wes	en eutopsy med?	24b. Were autopsy findings available prior to completion of cause of death?		
E							16	es 2 No	1AYes 2□ No		
BeC	25. Was case referred to medical				26	Place of Dec	oth (Check only o	ne)			
0	examiner?	Hospital:	2 ER/Outpatie	ent 3 DO	Other:		ome 5 Resid	v	(Specify) SCENE		
ation: T	27. Manner of Death 1	28a. Date of Injury (Month, Day Year) 28b. Time of Injury Work Work			8c. Injury at Work?		28d. Describe how injury occurred				
Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Placa of Injury - building, etc. (S	At home, farm, si pecify)	treet, factory	, offica		28f. Location (S City or Tow		er or Rural Route Number,		
edical	29a. Certifier 1☐ Certifying Phy (Check only one) 2☑ Medical Exami	sician: To the best of miner: On the basis of exa and menner stated.	y knowledge, deal mination and/or in	th occurred anvestigation,	at the time, d In my opinio	ate and place n, death occu	, and due to the or rred at the time,	cause(s) and ma date and placa, a	nner as stated. Ind due to the cause(s)		
Ž	29b. Signature and title of certifier			29c	. License nu	mber		29d. Dete signed	(Month, Day, Year)		
	11.1.11	V. J	/		O.C.M	E		TIME OF	2000		
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1							JUNE 2	L. 2000		
)	30 Name and address of person who a	ompleted cause of dooth	(Item 23a) (Time	Print\	O.C.M	. <u>L</u> .		OULVE 2.	2000		
completely filled in by the funeral director, page Medical Certification: To Be Com	30. Name and address of person who co								and 21201		

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State of Maryland / Department of Health and Mental Hygiene 22322. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** Kent Viehoever 6:55 PM 25 2000 Ture /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c, County of Death Examiner Heights 109 Seveca Drive rivce Georges If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 1[XM 2□ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Yes 119-24-0451 Director 73 Usual Residence of Decedent 10b. County 10c. City, Town or Location r than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 10d. fnside City Limits 1 ☐ Yes 2 ☐ XNo Director Maryland Prince Gerge's Forest Heights 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20745 U.S.A. 109 Seneca Drive death Funeral 12 Was Decedent Ever in U.S. Armed Forces? 1 DXYes 2 □ No 1944— If Yes, Giva Year or Dates: 1946 14. Race - American Indian, Black, White, etc. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0020 1 Yes 2 No Specify: Specify: 3∰Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. important: If Hem 27 is marked other than "na any injury or other traumatic event, the Medit 00.0. filed within Elamentary/Secondary (0-12) College (1-4or 5+) 12 8+ Research Psychologist U.S. Government Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumama) Viehoever Arno Mabel Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of comatery, crematory or other place) Mark Viehoever (Son) 20a. Method of Disposition 1 Burial Cremetion 3 Removal from State 4 Donation 5 Other (Specify) June 27, 2000 Lee Crematory Clinton, Maryland 21. Signature of Funeral Service Lices 22. Name and Address of Facility Lee Funeral Home, Inc. 6633 Old ALexandria Ferry Road Clinton, MD20735 Down X. LO 23a. Pert1. Enter the disease, or complications that ceused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) /Medical BLAddy CANCER with Metastasis Examiner Due to (or es a consequence of): Physician/Medical Examiner nding physician and use as the burial-transit Sequentially list conditions, if eny, leading to Immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760. The lew requires that the death certificate be Due to (or as a consequence of) signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings available prior to completion of ceuse of death? Be Completed 24a. Wes an autopsy N/A 1 Yes 2 DA 1 🗆 Yes Division of Vital Hospital or Attending Physician: director 25. Was cese referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 12 Yas 2 No this 27. Menner of Deeth 28a. Date of Injury (Month, Day Year) Medical Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 5 Pending invastigation 2- Natural s after dea... 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) lilled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral Completely filled 29a. Certifier 1 Certifying Phyalcian: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. 29b. Signatura and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H005 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) Cheverly 3001 31. Date filed (Month, Day, Year)
JUN 2 9 2000 State

DHMH 16 Rev 6/95

Registrar

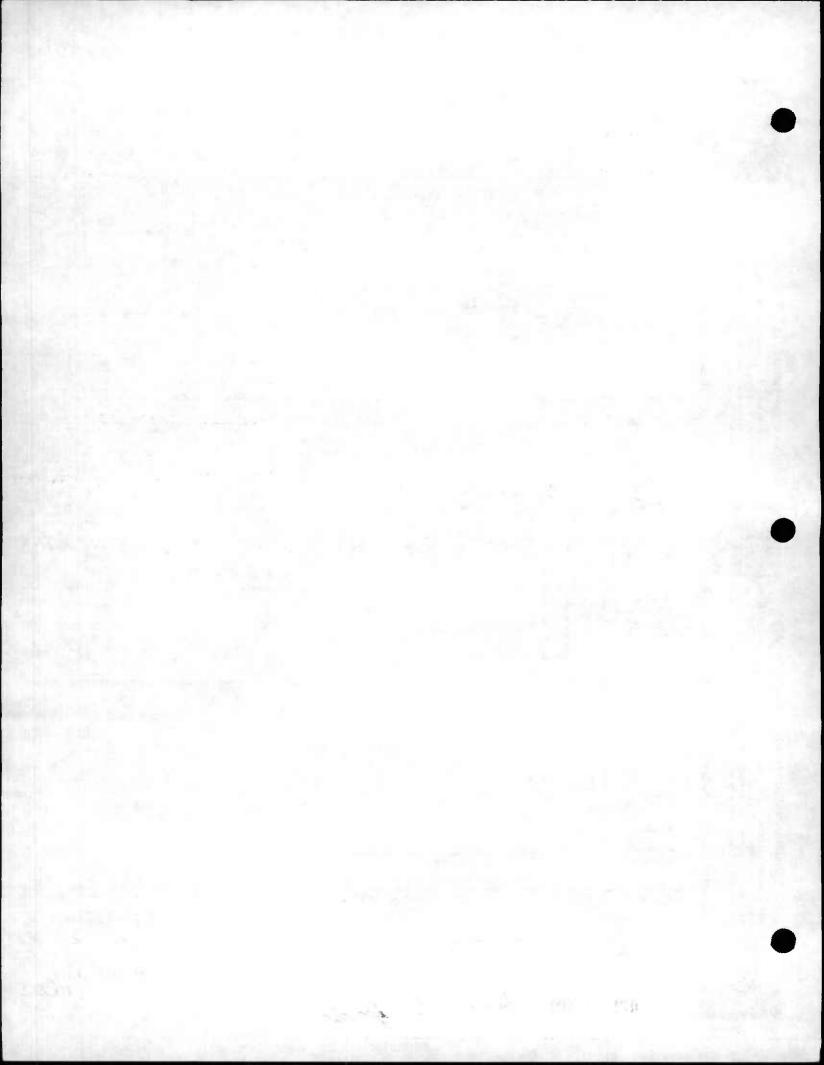
State of Maryland / Department of Health and Mental Hygiene 00 22323

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	5. Social Security			. Age (In yrs. la:	st birthday)		r 1 Yeer	if Under	24 Hrs.		of Birth h, Dey, Ye			nplace (State or Foreigntry)
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To	Elmer	Wiseman						Nel1	ie I	ee				
	19a. Informant's	Name/Relationship	(Type, Print)		19b. Maili	ing Addres	s (Street	end Numb	er or Rui	al Route N	lumber, Ci	ity or Town	n, State, Z	(ip Code)
	Esther	Wynn - Si	ster		6930	Emer	eon	Stree	t Hs	atts	v111e	MD 2	20784	
	20a. Method of D	isposition		20b. Pla	ce of Disponerery, crei	osition (Na	me of	no.		Date				Town, State
		2 Cremation 3		tate				atory		6-28-	00 41	ex VA	Λ	
		n 5 ☐ Other (Speci		Met.						0 20	OU AI	.CA VI	.,	
	21. Signature of	Funeral Service Lice	nsee		2			ss of Facili		1 Uo	mo T	no		
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State of Maryland / Department of Health and Mental Hygiene 00 22324

						ate of				Reg. No.		
	1. Decedent's Name (2. Date of De Month		Year	3. Time of Death
cian dical	RODERIC	ALONSO	WELCHER,	SR.						27,2000	1001	4:10AM
iner	4a Fecility Name (If n	_)					cation of Deet	th 4c. County		
	Pinevie	w Nursi	ing Home					nton		Pri	nce G	eorges
	5. Social Security Nun 577-66-706		Sex 7. A	ge (In yrs. lest bi 52	Yrs. If Un Mont	hs Deys	Hours Hours	24 Hrs. Min.	8. Dete of Bi (Month, Do			lace (State or Foreightry) h. D.C.
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		0b. County		10c. City, Tov	vn or Location						10	0d. Inside City Limit
Director	Maryland	Prince	George's	Suit	tland					71 Jan		1 ☐ Yes 2 🔀 N
-	10e. Street and Numb		s Road, #	103	10f.	Zip Code	2074	6		10g. Citizen of V USA	What Coun	try?
- Alleia	11. Marital Status	- 1	12. Wes Decedent	Ever in U,S.	13. Was De	cedent of H	lispanic Ori	gin? (Spe	ecify Yes or Ne Rican, etc.)	o- 14. Rac	a - America	
	1 ☐ Never Married 3 ☐ Widowed 4X		1 X Yes 2 □			s 2½ No	Specify:		riioari, etc.)	Specify	ck, White, e	
	15	5. Decedent's E	ducation		. Decedent's U	Jsual Occup	ation			16b. Kind of Bu		
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	Cleopha	as Welch	ner				Ju	stic	e 0. H	i 11		
	19a. Informent's Nem	e/Relationship	(Type, Print)	19	b. Mailing Addr	ress (Street	and Numbe	er or Rure	el Route Numb	ber, City or Town,	State, Zip	Code)
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_	· Spu	W. D	mert	and	6500	Allen	itown	Road	, Camp	Springs	, MD	20748
		diameter as the		date de de De							1	Assessments
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Jacqueline Lee 10:00 Am June 26,2000 /Medical 4a Facility Neme (In not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Savage 8886 Washington Street If Under 1 Year If Under 24 Hrs 5. Social Security Number 8. Dete of Birth (Month, Day, Year) January 28,1949 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday) **Funeral** Months Days 1 □ M 2 N F 51 Yrs. Director 215-52-5334 Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits than "naturel" or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2X No Director Maryland Howard Savage 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20763 United States 8886 Washington Street Funeral 12. Was Decedent Ever in U,S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel," or item enter injury or other traumatic event, trailing and enter traumatic event, trailing and enter traumatic event, trailing enter traumatic event, trailing enter traumatic event, trailing enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter enter Black, White, etc. 1 ☐ Never Married Ž Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Dates: Specifikhite þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Private Homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Florence Theresa Fauth Jack Coleman Rainey 19a. Informant's Name/Relationship (Type, Pnint) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8886 Washington Street Savage Maryland 20763 Andrew Wright (Husband) 20b. Place of Disposition (Neme of cometery, cremetory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☑ Cremetion 3 ☐ Removal from State 7-1-00 Brentwood, Maryland Fort Lincoln Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Fort Lincoln Funeral Home Inc 3401 Bladensburg Rd, Brentwood Md 20722 ellour 23a. Part. Enfer the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examiner physician and s the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Box 68760. that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Dtd tobacco use contribute to the cause of death? signed by 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 2 No 1 ☐ Yes 2 No certificate Division of Vital sepital or Attending Physician: hours after death. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 27. Manner of Death Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 4 Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1) Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end place, end due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated. 29e. Certifler 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number eted cause of death (item 23a) (Typa, Print) Johns Hopkins Hospital Baltimore, MD 21287 31. Date filed (Month, Dey, Year) 32 Registrar's Signeture State JUN 2 9 2000

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Registrar

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State of Maryland / Department of Health and Mental Hygiene 0 0 22327

permit. Pages 1 and 2 should be filed within 72 hours efter death with the Maryland

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760,

Registrar

1.	Certifi	icate of Death	R	eg. No.	
	Decedent's Neme (First, Middle, Last)	NEW THE PARTY	2. Dete of Deat Month		3. Time of the
	Martha Dowdy Wyche		-terms	27,200	
48	Facility Name (If not institution, give street end number)	4b. City, Town, or Lo	ocation of Death	4c. County of	
F	rince George's Hospital	Chever	y	Prince	George's
	Social Security Number 6. Sex 7. Age (In yrs. last birthdey)	Under 1 Year If Under 24 Hrs. onths Days Hours Min.	8. Dete of Birth (Month, Dey Jan 13	Year)	B. Birthplace (State or Foreign Country)
2	38587//2 10 M 2 MF 95 Yrs. MS		Jan 13	1905	"nc
_	sual Residence of Decedent Da. State 10b. County 10c. City, Town or Location				10d. Inside City Limit
11	110	-1-			1 ☐ Yes 2 N
_	NC Washi				
i€	De. Street and Number	Of. Zip Code	'	0g. Citizen of Wh	et Country?
_	1ag W. 6 Street	21887			317
1	Armed Forces? If Yes	Decedent of Hispanic Origin? (Sp s, specify Cuban, Mexican, Puerto	Rican, etc.)		American Indian, White, etc.
	1 Never Married 2 Married 1 Yes 2 No 1 S (Widowed 4 Divorced Year or Dates:	Yes 2 No Specify:		Specify:	Black
-		s Usual Occupation		16b. Kind of Busi	
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	Elementery/Secondary (0-12) College (1-4or 5+)	Eacher		Public	School
7	7. Father's Neme (First, Middle, Last)	18. Mother's Nam	e (First, Middle, I	Maiden Surname,	
	Moses Dowdy	Joahn	a H	unter	
1		ddress (Street end Number or Rui			
	nelville O. Wyche Jr 11903 S	st. Francis L		•	1
-	Da. Method of Disposition 20b. Place of Disposition	n (Neme of			ity or Town, State
	1 ☐ Buriel 2 ☐ Cremetion 3 ☑ Removal from State		129/00	Jachin	ston, nc
2	4 Donation 5 Other (Specify) 1. Signature of Funeral Service Licensee 22. Na	me end Address of Fecility Gy			
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_		ranklin St. Ale			
2	3a. Part1. Enter the disease, or complications that ceused the death. Do not enter the shock, or heert feilure. List only one ceuse on each line.	e mode of dying, such as cardiac	or respiretory err	est,	Approximete Interval Between
					Onset end Death
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22328 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Tima of Death **Physician** 16/3 lune 20 2000 Jerome Wahl Williams /Medical 4e Facility Name (If not institution, give street end number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Georges rivce ince CVer/4 Hours Min. 8. Cate of Birth (Month, Dey, Year, May 14, 19 5. Social Security Number 6. Sex 7. Age (In grs. lest birthday) If Under 1 Yeer Birthplace (State or Foreign Country) **Funeral** 1⊠M 2□ F Months Deys Yrs. 500-24-5604 **Director** Missouri Usuel Residence of Decedent 10c. City, Town or Location 10a. State "natural", or items 23s or 28s-4 show adical Examiner must be notified at 10b. County 10d. Inside City Limits MD Prince George's Forestville 1X Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1657 Tulip Avenue 20747 U.S.A. Funeral 14. Race - American Indian, 12. Was Decedent Ever in U,S. Armed Forces? 1. Yes 2 □ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Meritel Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married Specify: Black 1 Yes 2 No Specify: 3X Widowed 4 ☐ Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Administrator 5+ Government permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event page. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Benjamin Vernon Williams Sr Luprenia Catherine Holiday 19a. informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Jerome B. Williams -son 1657 Tulip Avenue Forestville MD 20747 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Resurrection Cemetery 6-28-00 Clinton Maryland 4 Donation 5 Dother (Specify) Entandment 22. Name and Address of Facility J.B. Jenkins Funeral Home 7474 Landover RD Landover MD 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset end Deeth **Physician** /iviedical Immediate Cause (Finel disease or condition resulting in death) mone **Examiner** Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings evellable prior to completion of cause of deeth? Le whites u leizs 24a. Was an autopsy performed? Encenhalopathy due to head misery 1 Yes 2 No 1 Yes 2 No 25. Was case reterred to medical exeminer? Be 26. Plece of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2□ No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28d. Describe how injury occurred Patient chest Slipped, struck head & chest 27. Menner of Deeth 28a. Date of Injury (Month, Dey Year) 28b. Time of 28c. injury at Work? 5 Pending Investigation (Month, Dey rear)

MALCA 28,200 5:00 M

10

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 1 Natural 1 Yes 2 No 2 Accident

The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, or Attending Physician:

signed by the a is certificate h this After thi Director: / To the Hospital or within 24 hours aft To the Funeral Di completely filled in

be filed within 72 hours after death with the Maryland al Hygiene.
other than "naturef", or fiems 23s or 28s-4 show

0 State

edica

6 Could not be

3 Suicide

29a. Certifier (Check only one)

4 Homicide

29c. License number

, May Ind Forestville Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution | Constitution 29d. Date signed (Month, Dey, Year)

281. Location (Street end Number or Burel Boute Number City or Town, Stete)

29b. Signature end little of certified 501852

30 Name and eddress of person who completed cause of death (Item 23e) (Type, Print)
PNI A DEVORE MD 4 2031 Quecus bury Rd Hyattsville MD 20781 31. Date filed (Month, Dey, Year)

Registrar

JUN 2 7 2000

32 Registrar's Signature

3005 F 8 MUC

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

RIGHT	State of Maryland /	Department of Health
mend item 23a.27 per me		Cartificate of Dooth

and Mental Hygiene

amend it	tem 23a,27 per me G785 7	7/14/00 yg	Certificate of	of Death	Reg. No.	0 22329
Physician	1. Decedent's Name (First, Middle, Las			2. Date Mor	e of Death onth Day	3. Time of Death
/Medical	WAYNE ANTONIO WRIG			JUI		2000 18:30 PM
Examiner	4a Facility Name (If not institution, give			4b. City, Town, or Location of		
	2920 OXON PARK ST		last hirthday) If Under 1 Ye	TEMPLE HILL par If Under 24 Hrs. 8, Date	S PRING	CE GEORGE'S
Funeral Director	210 90 0940	8X M 2□ F 7. Age (m y/s. 33	Yrs. Months Da	ys Hours Min. July	7 25, 1966	9. Birthplace (State or Foraig Country) Sumter, S.C.
9 1	Usuat Residence of Decedent 10a. State 10b. County	10c. Ci	ty, Town or Location			10d. Inside City Limit
with the Marylar a or 28a-f show be notified at Director	Maryland Prince G		emple Hills			1 ☐ Yes 2 ☐ N
or 28a-f s or 28a-f s be notified	10e. Street and Number	corge 3	101. Zip Cod	A	10g. Citizen of V	Vhat Country?
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72 hours after deal lical Examiner in sted by Funer	1 Nevar Married 2 Married	Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	If Yes, specify C			k, White, etc. Black
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ed within 72 ho ygiene. er than "natur f, the Medical. Completed	(Specify only highest gra	College (1-4or 5+)	lifa. DO NOT use re	ne during most of working tired)		
Man Po	12th		Patient Tra	ansporter	Priva	te Hospital
distributed of other sevent	17. Father's Nama (First, Middla, Last)			18. Mother's Name (First,		(0)
Menta Menta wheel wheel To E	James C. Wright			Hallie Q. Ke	ennedy	
2 sho	19a. tnformant's Name/Retationship (7	Type, Print)	19b. Maiting Addrass (Str	eet and Number or Rural Route	Number, City or Town,	State, Zip Code)
and 2 valith er fri	James C. Wright/f	ather	2920 Oxon Pa	ark Street Temp	ole Hills,	MD 20748
T age	20a. Method of Disposition		Place of Disposition (Name of cemetery, crematory or othar	place) Data	20c. Location -	City or Town, State
Pages sent of int: if th ary or o	1 Burial 2 Cremation 3 □ 4 Donatlon 5 Other (Specify	Hemoval from Stata Wa	shington Natio	onal Cem 7-10	Suitlan	d, MD
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death certificate be executed e attending physician and of for use as the burial-transit sician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequanca of):			
E 50	that initiated events resulting in death) Last	Due to (d	or as a consequence of):			t t
at the death ce d by the attendir etached for use Physician/	Part II. Other significant conditions co		sulting in the undarfying cause	givan in Part I. 23	b. Did tobacco use co	ntribute to the cause of deat
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been s should				24	a. Was an autopsy performed?	24b. Ware sutopsy findings available prior to completion of causa of death?
0 - 8 E	The Court of the Court of			A 755 W	1 Yes 2□No	1XYes 2□No
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within 7 To the comple	29b. Signatura and title of certifier		29c. Lic	ense number	29d. Date signe	d (Month, Day, Year)
->-0	V. 1	N. 14		OCME	TITESE	F 2000
	30. Nama and address of person who d	completed cause of death (lies	m 23a) (Type Print)	O.C.M.E.	JULY	5, 2000
	Tory of Line	C M 1)		Chront Dull		21201
Ctoto	31. Date filed (Month, Dav. Year)	32. Registrar's Sign		Street, Baltin	ore, maryli	and STSAT
State Registrar	31. Pate filed (Month, Day, Year)	32. Registrar's Sign			7	

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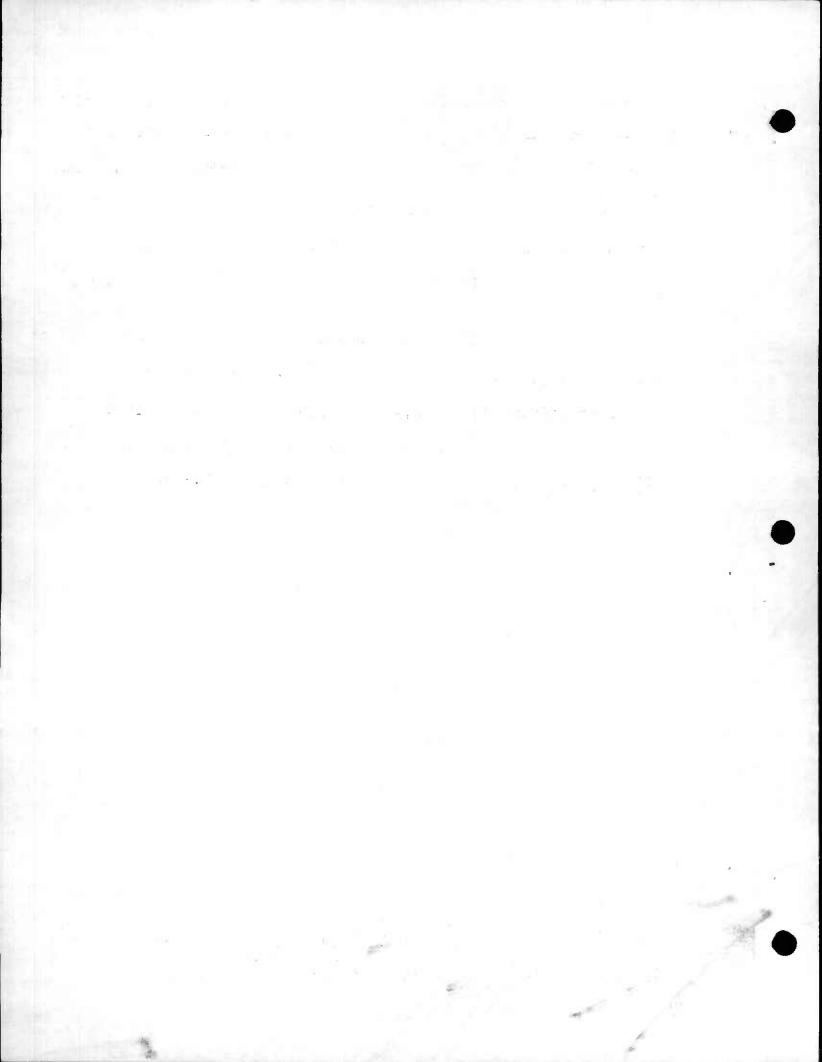
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State of Maryland / Department of Health and Mental Hygiene

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	Hosp 24 hor Fune etely fi	edicai		ysician: To the best of m niner: On the basis of axi and mannar steted	amination and/or inv						
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			CharlesF-0	'VONY) B3	tima	remd:	11210		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death Day Month Vear **Physician** RICHARD LARRIMER WHITTINGTON 21 June 2000 7:25 PM /Medical 4e Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Genesis ElderCare -The Pines Easton Talbot Birtholece (State or Foreign Country) If Linder 1 Year 8. Dete of Birth (Month, Dey, Yea May 23, 1 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** SAX 14∑M 2□F Months Days Hours Yrs 1923 215-12-6385 77 Director Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show tem 27 is marked other than "natural", or items 23s or 28a-f show other traumstic event, the Medical Examinat must be notified as 1 Yes 2 No Directo Maryland Talbot St. Michaels 10e. Streef and Number 10f. Zip Code 10g. Citizen of What Country? Nema 23a 215 Madison Ave. 21663 U.S.A. Funeral permit. Peges 1 and 2 should be filed within 72 hours after dea.
Department of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural". or house any injury or other traumatic event 14. Reca - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritel Status 1 □ Yes 2 □ No WWII If Yes, Give Year or Dates U.S. Navy 1 Never Married 2 Merried Richard Whittington Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specity: White þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 11 Printer Waverly Press 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) 36 John L. Whittington Alma Louise Larrimer 2 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) 26273 Daffin Rd. Shelley S. Mielke Daughter Easton, Maryland 21601 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State Dete 4 ☐ Donetion 5 ☐ Other (Specify) Olivet Cemetery June 24,2000 St. Michaels, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Fecility Harrison E, Leonard Funeral Home 312 S. Talbot St. St. Michaels, Maryland 21663 Leonsine 23a. Pert1. Enter the disease, or complications that caused the death. shock, or heert tailure. List only one cause on each line. Approximete tntervel Between Onset end Death Do not enter the mode of dving, such as cardiac or respiretory errest, **Physician** /Medical Immediate Cause (Final MUKTA diseese or condition resulting in death) Examiner Due to (or as a consequence of) Examiner physicien and s the burial-transit that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Due to (or es a consequence of): for use as Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23h. Did tobacco use centribute to the cause of death? Records, P.O. signed by t d be detech 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings evaileble prior to completion of cause ot death? 24e. Wes en eutopsy performed? Completed peeu Sec 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate of Vital Physician: 25. Was case referred to medical examiner? 80 26. Place of Deeth (Check only one) Hospital: Other: Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 → No 1 Inpatient 2 ER/Outpatient 3 DOA After this o 28a. Date of tnjury (Month, Day Year) 28c. Injury et Work? Medical Certification: 27. Menner of Death 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Division 5 Pending investigation 1 Maturel Injury after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 12 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. 29e. Certifier completaly 29b. Signeture end title of certif) 29c. License number 29d. Date signed (Month, Day, Year) MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21601 508 J DANCHEZ MD LOBERT

State

Registrar

31. Dete filed (Month, Day, Year) JUN 2 6

32. Registra/s Signature

2000

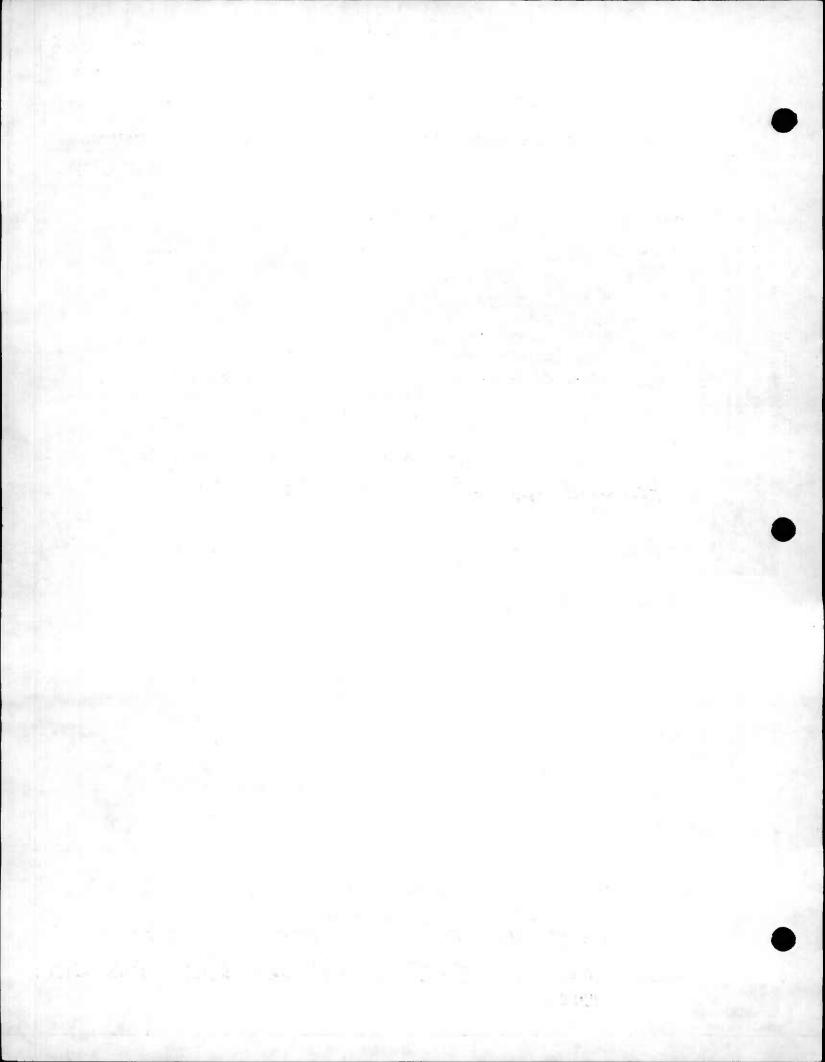
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State of Maryland / Department of Health and Mental Hygiene 00 22332

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xaminer	4a Facility Nama (If not institution	n, give street and numbe	r)		4b. City, Tow	n, or Location of De	ath 4c. Count	of Deeth	
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neral	5. Social Security Number	6. Sex 7. / 1 ☐ M 2 ☒ F	age (In yrs. last birthda)	Months Deys		4 Hrs. 8. Data of I Min. (Month,	Birth Dey, Year)	9. Births	oleca (State or Foreign
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Funeral Director	MD TA	LBOT	EAS	ION					1X Yas 2 □ No
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dle	(Check only 2 Medical one)	Examiner: On the basis end manner	of examinetion and/or i	nvestigetion, in my	opinion, deet	occurred at the tim	e, date and placa	and due t	o the cause(s)
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DHMH 16 Rev 6/95



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State of Maryland / Department of Health and Mental Hygiene 22333 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month **Physician** 28, ZUUU 4c. County of Death Catherine Walker June 9:15PM /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner Prince George's Co. 11203 Cranford Drive Upper Marlboro | Hunder 1 Year | Hunder 24 Hrs. | 8. Data of Birth | 9. Birthplaca (Stata or Foreign Months | Days | Hours | Min. | March | 27, 1941 | Maryland 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** 1□ M 20XF Yrs Director 59 213-40-4620 Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23s or 28s-f shor Upper Marlboro 1 Yas 2 No Prince George's Co. MD Director and Mental Hygiene, and Mental Hygiene, and Mental Than "natural", or frams 23s or 28s-f 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? U.S.A. 20772 11203 Cranford Drive Funeral 14. Raca - American Indian, Bleck, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lt Yas, specify Cuban, Maxican, Puerto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? filed within 72 hours after 1 Yes 2 No If Yas, Giva Year or Detes: 1 ☐ Never Merried 2 ☑ Merried Saltimore, Maryland 21215-0020 Specify: White 1 Yas 2 No Specify by 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedant's Usual Occupation (Give kind of work dona during most of working lifa. DO NOT usa ratired) 16b. Kind of Business/Industry 15. Decedant's Education (Specify only highast grada completed) Elamantary/Secondary (0-12) Collega (1-4or 5+) Home Homemaker 12 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Sumame) Be pamit. Pages 1 and 2 should be Department of Health and Mental Important: If fleen 27 is marked o Ellen Fallon Murray Simon Thomas Kenny 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informant's Name/Ralationship (Type, Print) 11203 Cranford Dr. Upper Marlboro, MD 20772 (Husband) Albert A. Walker 20b. Placa of Disposition (Nama of cemalary, cramatory or other placa) 20c. Location - City or Town, Stata 20a. Mathod of Disposition July I D Burial 2 ☐ Cramation 3 ☐ Ramoval trom State 3, 2000 Hagerstown, MD Rose Hill Cemetery 4 Donation 5 ☐ Other (Specify) 21. Signature of Sonthai-Se 22 Name and Address of Facility
Lee Funeral Home Calvert, P.A. 8125 Southern Maryland Blvd. Owings, MD 20736 23a. Part1. Enter the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failufe. List only one cause on each line. Approximata Interval Batween Onset end Daeth **Physician** Immediata Causa (Final disaasa or condition rasulting In death) ENCEPHANOLATHY /Medical Examiner CIRRHOSIS Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immadiata cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last the burial-tran Due to (or as e consequence ot) P.O. Box 68760. attending physician Physician/Medical Due to (or es a consequenca of) 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, þ cate hes been sign, page 2 should b 24b. Wara autopsy findings aveilabla prior to completion of causa ot daath? 24a. Was an autopsy performed? Completed certificate hes 1 Yas 2 KNo 1 ☐ Yas 2 X No vurs after death.

eral Director: After this certifics filled in by the funeral director, or Attending Physician: 25. Was casa ratarrad to medical axaminar? Be 26. Placa of Death (Check only ona) Hospital: 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA Othar: 4 ☐ Nursing Homa 5 ☑ Rasidance 6 ☐ Othar (Specify) 2 1 ☐ Yas 2 No Certification: 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 5 Pending invastigation 1 Yas 2 No 2 Accidant 28t. Location (Street and Number or Rural Route Number, City or Town, Stata) 6 Could not be 3 Suicide 28a. Placa of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 | Homicida To the Hospital of within 24 hours a To the Funeral D 29a, Certifiar Medical completaly 29d. Data signed (Month, Day, Year) 29c. Licansa number 29b. Signatura and til 46478 MA

DHMH 16 Rev 6/95

State Registrar

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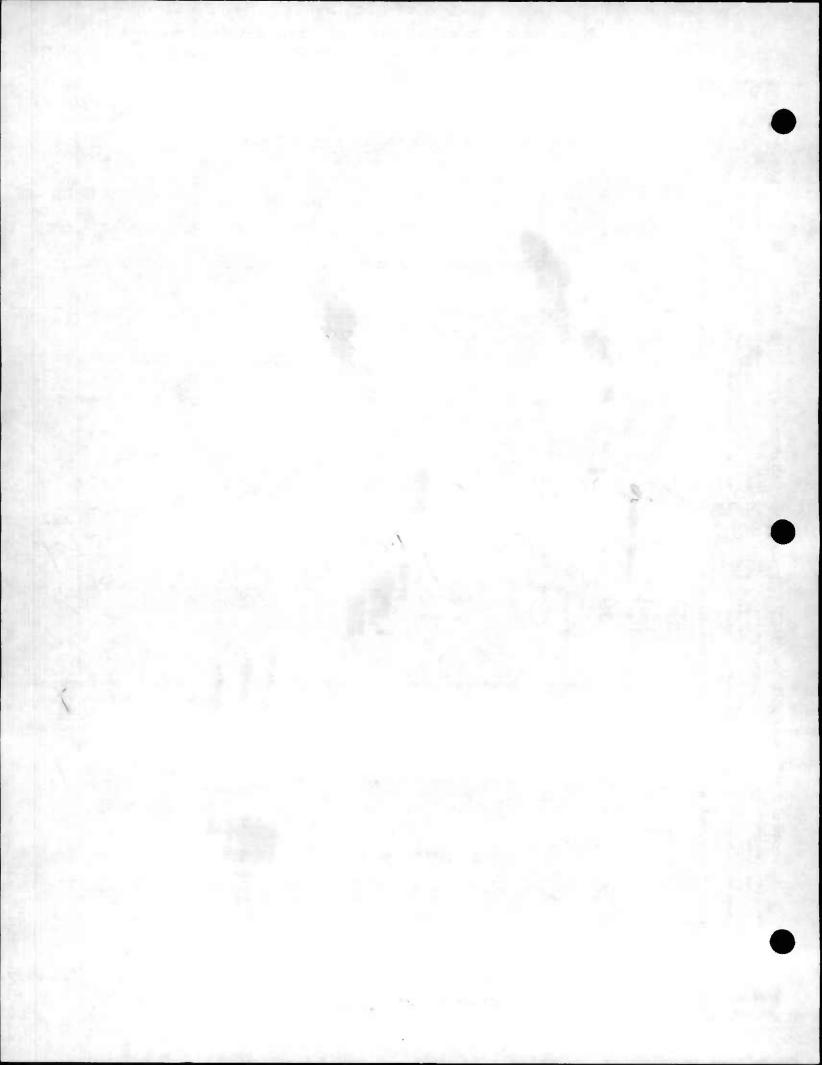
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30. Nama and addrass of person who completed causa of deeth (Item 23a) (Type, Print)

2000 32. Registra's Signeture

Suresh Patel M.D.

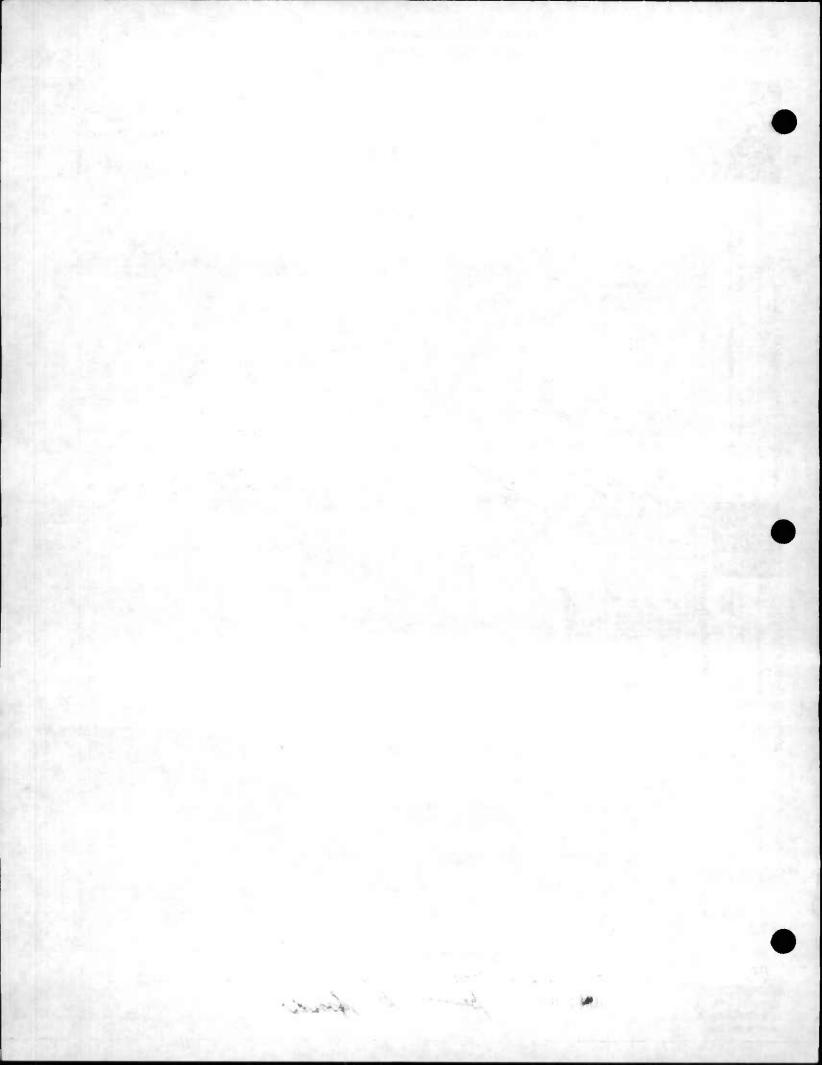
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State of Maryland / Department of Health and Mental Hygiene 00 22334

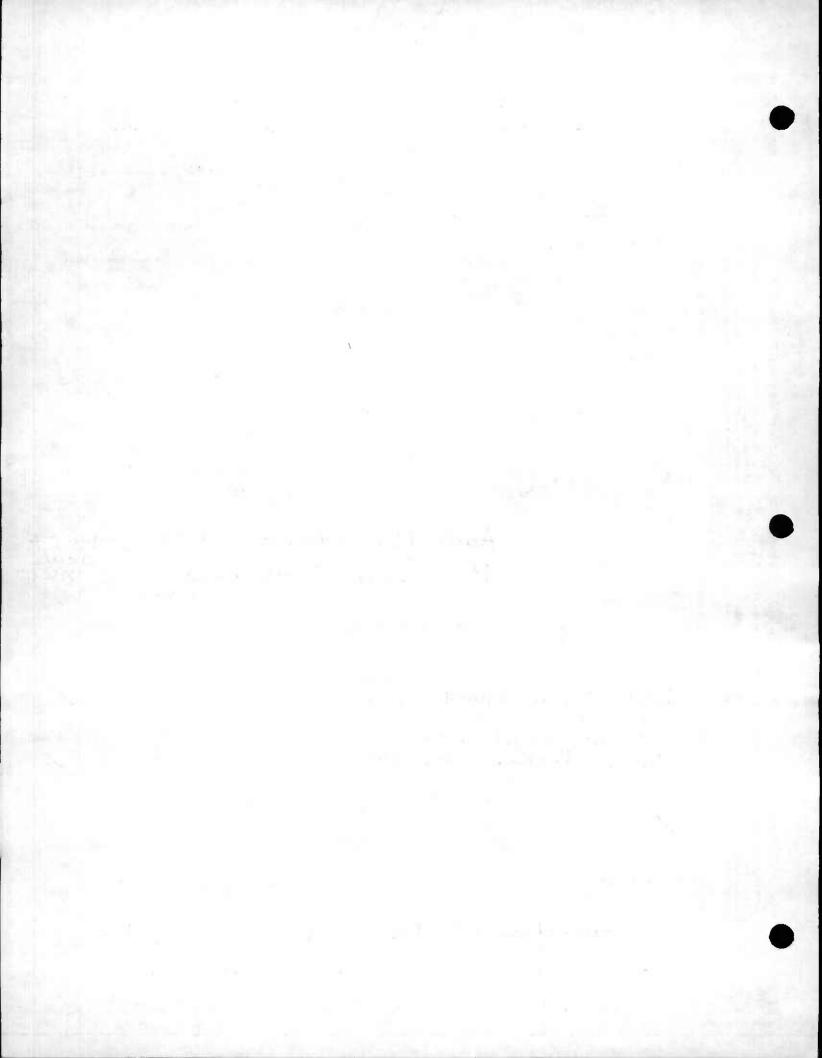
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Tima of Death Day 2000 **Physician** Agatha Gwendolyn July 03, Walter 10:04AM /Medical 4a Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Civista Medical Center La Plata Charles If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) July 25,1922 7. Age (In yrs. last birthday) Birthplace (Stata or Foreign Country) **Funeral** Days 1 M 200 Months Hours 214-76-3690 Yrs Director Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits must be notified at 1 ☐ Yes 20 No Director Maryland Charles Hughesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13987 Burnt Store Road 20637 Funeral S. A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 24 No If Yes, Give Year or Dates: 'natural', or Items 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 Never Married 2 Married 3altimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: ģ 3₺Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Homemaker At Home filed 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and 2 should be saith and Mentai marked Samuel Cleveland Cooksey Florence Madeline Murphy permit. Pages 1 and 2 should Department of Health and Milmportant; if item 27 is mart any injury or other traumati 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert Mark Walter/Son 5415 Sandy Pt. Rd. Prince Frederick, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition July 1 Burial 2 □ Cremation 3 □ Removal from State 17,2000 4 ☐ Donation 5 ☐ Other (Specify) St. Mary's Church Cem. Bryantown, Maryland 22. Name and Address of Facility
Brinsfield-Echols Funeral Home, PA 21. Signature of Funeral Service License M00641 30195 Three Notch Rd.Charlotte Hall, MD 20622 23a. Part1. Effer the disease, or copplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Physician Myocardial infarction Immediate Cause (Finat disease or condition resulting in death) /Medical Examiner Physician/Medical Examiner onse mertenome that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es a consequence of): physician s the buria Box 68760, Due to (or as a consequence of) P.O. Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown morphism in sortains Chronic Records, à 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy performed? Sindrom enal MYDNIC Division of Vital Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yas 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? 1 Natural 2 Accident a Euneral Director: Afte Funeral Director: Afte bletchy filled in by the fun 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide 5 Y Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and mannar stated. edicai 29a. Certifier To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3 00 D-27189 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Zahir Yousaf, MD Cenna Center 7-Y Post Office Road Waldorf, Maryland 20602 31. Date tiled (Month, Day, Year) State 32. Registrar's Signature Seneva Registrar JUL 0 5 2000

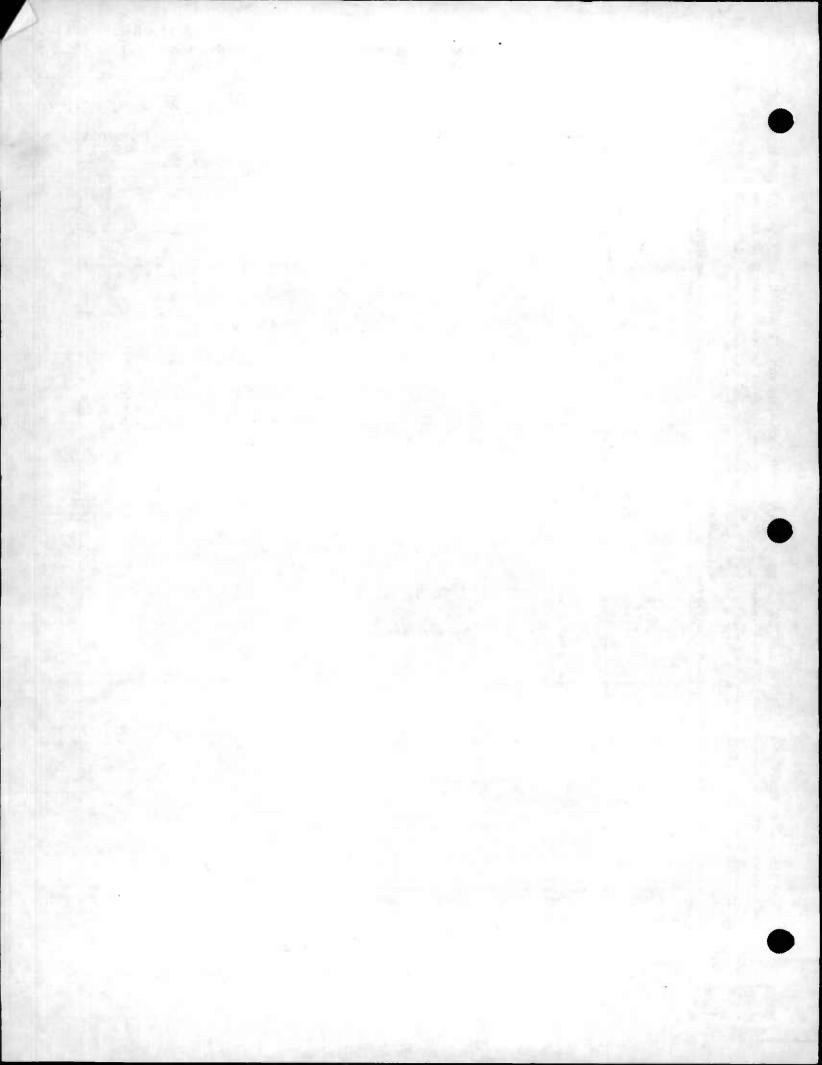


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Physician KATHRYN CREECH WARD	3. Time of Death
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29b. Signeture end title of cartifier 29d. Date	signed (Month, Dey, Year)
J. Steve Julian MD D41813 6/	26/00
25 30. Namerand address of person was completed cause of death (Item 23a) (Type, Print), Stew Julian MO 201 Pine & Affred Sulisbing	MD 2180/
State Registrar JUN 2 6 2000 32. Registrer's Signeture	

Kathern Warel



Registrar

JUL 14 2000

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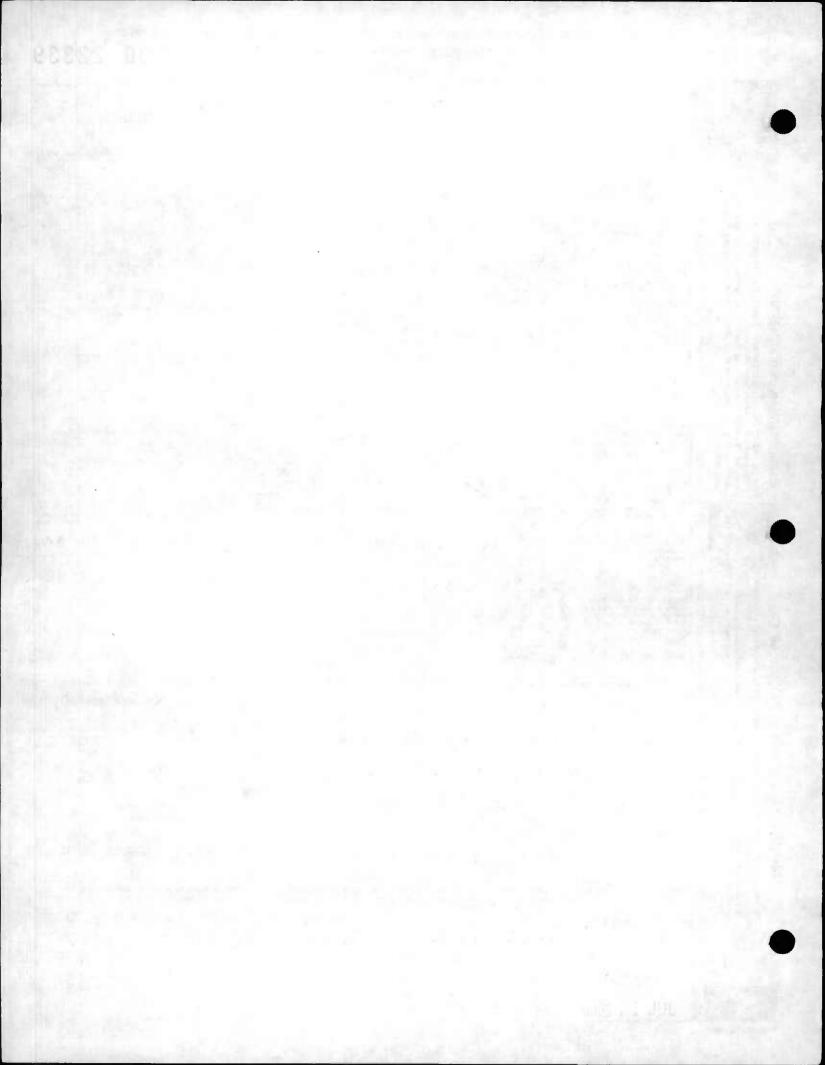
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Funeral	5. Social Security Number 6. Sex 12 M 2 F 7. Age (In yrs. last birtho	Months Days Hours Min. 8.	Date of Birth Month, Dey, Year, AN, 12, 1930 M	rthplace (State or Foreign Country)
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Page Page Page Mary or uny or	1 ABurlat 2 Cremation 3 Removel from State 4 Donation 5 Other (Specify)	HORE NATIONAL 9-X	5-00 BALTIMOR	E, MARYLAND
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M 805 8 8	Slownin	2140 N. FULTON	AVE BALTO, N	10.21217
	23e. Part 1. Enter the disease, or complications that caused the death. Do not book, or heart failure. List only one cause on each line.	enter the mode of dying, such as cardiac or re-	spiratory arrest,	Approximate Interval Between
Physician	244	1-11.		Onset and Deeth
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Myocardia	1 Intarction	1	1 hour
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death certifix e attending pot for use as	- 0.			
	Part tt. Other significant conditions contributing to death but not resulting in the	ne underlying ceuse given in Part t.	23b. Did tobacco use contribu	
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f Vital Re is yelclen: The is scentificate he director, page	25. Was case referred to medicat	26. Place of Deeth (C		
of Vita Physician: This certific		etient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Sp	pecify)
On O			. Describe how injury occurred	
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Division O' To the Hospital or Attending Ph Within 24 hours either deeth. To the Funeral Director: After thi completely filled in by the funeral Madical Certification:	29a. Certifier 1 properties 1 certifying Physician: To the best of my knowledge, d (Check only one) 2 ■ Medical Examiner: On the basis of examination and/cone) and menner stated.			
within 2 To the comple	29h Signature and title of certifier	29c. License number	29d. Date signed (Mo.	nth, Dey, Year)
(1)	Elim (Sem)	D38956	July.	10,2000
Maria	30. Name and address of person who completed cause of death (Item 23a) (T)	D38956 Loch Raven Blvd,	2 11	11 21239-
SA	KAWArd SeidelMD, 56011	och Kaven Blvd,	Buttimore 1	ND 2995
State	31. Date filed (Month, Dey, Year) 32. Registrar's Signature	4 Aprila		
Registrar	JUL 1 4 ZUUU	- pyrians		

DHMH 16 Rev 6/95

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State of Maryland / Department of Health and Mental Hygiene 00 22339

			C	ertificate d	of Death	1	F	leg. No.		
	1. Decedent'a Name (First, Middle	a, Last)		E. 1			Data of Dea Month	th Day	Year	3. Time of Death
Physicia: /Medica		7	ARA	N		-	Salu		000	04:50 AN
Examine	4a Facility Name (If not institution	, give street and number)			4b. City, To	own, or Locati	on of Death			
	Johns Hor	okins Hos	pital		BALL	MORE	Cita	1		
Funeral	5. Social Security Number	6. Sex 7. Age (In	yrs. last birthde	y) If Under 1 Y	ear If Under	r 24 Hrs. 8.	Date of Birtl (Month, De)		9. Birthp	place (Stete or Foreign
Director	213-94-1695	¹¼™ 2□F 21	Yrs.	IN ONLIS DE	110013			, 1978		to Rico
9 .	Uaual Residence of Decedent 10e. State 10b. County	140	c. City, Town or	Lacation						and tools O'm block
aryla aryla arhon			c. City, Town or	Location						1 ☐ Yes 20XNo
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6 88	10e. Street and Number			10f. Zip Coo				10g. Citizen of	Whet Cou	ntry?
seeth with the Maryland ms 23s or 28s-f show mast be notified at	1357 Jamestown				1144	11000 "		USA	a Amad	to to to
for death reference 23 inserman	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U,S. 13	 Was Decedent if Yes, specify (or Hispanic Oi Cuban, Mexica	ngin? (Specify in, Puarto Ric	an, atc.)		ck, White,	etc.
020		led 1 ☐ Yes 2 ☒ No If Yes, Give Year or Detes:	9334	1 ☐ Yes 2.■	No Specify	<i>r</i> :		Specif	v: Wh	nite
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The law requires that the death of the law requires that the death of tale has been signed by the attenue page 2 should be detached for under the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of							24a Was	an autopsy	24b. W	ere eutopsy findings
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Vita iclan settifi ector	25. Was cese referred to medical examiner?	Hospital: No.				ce of Death (C	check only o	ne)		
thysic all dire		Hospital: 1 Inpatiant						lence 6 Dott		(y)
Division of Vital Records, tal or Attending Physician: The law requires the selectors. After this certificate has been signed in by the funeral director, page 2 should be considered.	27. Manner of Death 1 Netural 5 ☐ Pendin	28a. Date of Injury (Month, Dey Yea	28b. Time Injury		Injury at Work?		I. Describe i	now injury occur	rred	
Vision Attending or death. ector: After by the fune	2 Accident Invastig	not be			1 Yes 2		Location (Placed and Alice	h	al Davida Mumbar
or An	4 ☐ Homicide determ	28e. Place of Injury - building, etc. (St	At home, tarm, pecify)	street, factory, or	lice	201	City or Tov		Der Or Mur	al Route Number,
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he Hospit in 24 hour he Funer pletely fill	29e. Certifier 1 Certifyin (Check only one) 2 Medical (g Physician: To the best of my Examiner: On the basis of exa- and menner steted.								
thin thin and the	29b. Signature and title of certifier			29c. Lie	ense number			29d. Date signe	ed (Month.	Dav. Year)
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		· OGUNLES	(I , (V(, I)	JUTT.	J. 1 L	317 011		, 60	MLTI	MORE, MD 212
State	31. Date filed (Month, Day, Year) JUL 14 2000	32. Registrar's S	griature So	all						
Registra	JUL 1 4 (000	1								



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22340 amend item 10c per fh G785 7/14/00 yg Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** Month July 12, Maurice L. Alban 11:15 p.m. 2000 /Medical 4e. Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner Westminster Nursing & Rehabilitation Center Westminster Carroll | Months | Days | Hours | Min. | Reb. 4, 1911 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
Hampstead, Md. **Funeral** 1 M 2 F 214-16-0364 89 Director Usual Residanca of Decedant 10a State 10b. County 10c. City, Town or Location 10d. inside City Limits 7 is marked other than "natural", or items 23s or 28s-f sh traumatic event, the Medical Expressive must be notified Manchester Director 1 ☐ Yes 2 ☐ No Md. Carroll 3316 Wilhel 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 3316 Wilhelm Lane 21102 U.S.A. Funeral 12. Was Decedent Evar in U,S. Amed Forces? 1 ☑ Yes 2 ☐ No If Yes, Giva Yeer or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Maritei Status 14. Raca - American Indien, Bleck, White, etc. 1 Never Merried 2 Married 1 ☐ Yes 2 ☐ No Specify: Specify: White ρ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decadant's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Business/Industry offher than Elementary/Secondary (0-12) College (1-4or 5+) DeGarmo Construction Co. Gen. Contractor permit. Peges 1 and 2 should be file Depertment of Health and Mental Hy Important: if item 27 is marked other any file injury or other traumatic event AREs. 17. Father's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Meidan Surneme) Be Charles Edward Alban Sarah J. Mays 19a. Informent's Name/Ralationship (Type, Print) 19b. Malling Address (Straat and Number or Rural Route Number, City or Town, Stete, Zip Code) Robert T. Alban - nephew 3917 Benton St. N.W. Washington, D.C. 20007 20b. Pleca of Disposition (Neme of cemetery, cremetory or other plece) 20a. Mathod of Disposition 20c. Location - City or Town, State Date 1 Buriai 2 ☐ Cremation 3 ☐ Removal from State Manchester U.C.C. Cem. 4 ☐ Donetion 5 ☐ Other (Specify) July 17, 2000 Manchester, Md. 21. Signature of Funeral Service Licansee 22. Name end Address of Facility Eckhardt Funeral Chapel Anter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, or heart failure. List only one ceusa on each lina. unbon Approximete
Interval Batween
Onset end Death Pinrt T. **Physician** /Medical immediete Cause (Final disease or condition resulting in death) METASTATIC CANCER OF COLON 14 CAR **Examiner** Due to (or as e consequence of): Examiner Sequentially list conditions, if eny, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last the buriel-tran Due to (or as a consequenca of): ed by the attending physician deteched for use es the burie Physician/Medical Due to (or es e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Hrhknown by 24b. Were autopsy findings available prior to completion of causa of daeth? Completed 24e. Was an eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Was case rafarred to medical examiner? 26. Piaca of Death (Check only ona) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 1 Yes 2 No After this 27. Manner of Death 1 ☑ Netural 28e. Data of injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending Investigation efter death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 2 4 T Homicide within 24 hours e To the Funeral I. 1 Certifying Physician: To the best of my knowledga, daath occurred at tha time, date end place, end due to the ceusa(s) end manner as stated.

2 Medical Examiner: On the basis of axamination end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) end manner stated. Medical 29a. Cartifier (Check only one)

4 State

Registrar

filed within 72 hours efter death with the Meryland

21215-0020

Baltimore, Maryland

The law requires that the death certificate be executed

or Attanding Physician:

Hospital

5

Division of Vital Records, P.O. Box 68760,

31. Date filed (Month, Day, Yeer) JUL 14 2000

29b. Signature end title of cartifiar

32. Regiarar's Signeture

INTERIST, MEDICINE

30. Name end address of person who completed cause of death (Itam 23a) (Type, Print) Stoner AV, Westminister MD 21157

29c. License number

D 52035

29d. Date signed (Month, Day, Yaar)

AND THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRACT OF THE CONTRA ME STATE OF THE REAL PROPERTY. World spirit percentago and an extent that a second spirit and the second second THE PROPERTY OF THE PERSON NAMED IN THE PERSON NAMED IN

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2 Date of Death Day Year **Physician** 55 22 BAKROW CHALLOTTE 07 00 06 /Medical 4e Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE UNIVERSITY OF MANUENTS HOSP. MAL If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) If Under 1 Year Months Days Birthplace (Stata or Foreign Country)
 PA 5. Social Security Number 6. Sex **Funeral** 1 M 20 Days 042-34-7421 83 Yes Director Usual Residance of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at MY West Seneca 1 ☐ Yes 2 No Director Frie 10g. Citizen of What Count 10e. Street and Number 10f. Zip Code 725 Main Street 14224 Norma 23a death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐XNo If Yes, Give Yeer or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, Whita, etc. 11 Meritel Stetus permit. Pagas 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiena. Important: If itsm 27 is marked other than "natural", or iten any injury or other traumatic event, the Mental Exemina 1 Never Merried 2 Merried Baltlmore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 37 Widowad 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) HOMEMBREY 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) College (1-4or 5+) Own Home 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Perry W. Barrett Nellie Mae Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Name/Ralationship (Type, Print) Joyce Barrow / Daughter 3930 Brian Court, Hamburg, NY 14075 20b. Place of Disposition (Name of cemetery, crematory or other place D. Tonkin Corporation 20e. Method of Disposition Data 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Crametion 3 Memovel from State July 11, 2000 Tonawanda, 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funeral Service Licensee Victor P. Doda, Jr. 22. Name and Address of Facility
Charles L. Stevens Funeral Home, Inc.
1501 Fast Fort Avenue, Baltimore Maryland 21230 23a. Pert1. Enter the disease, or complications that cau and the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximete Intervat Between Onset and Death **Physician** Immedieta Causa (Final diseese or condition rasulting in daath) /Medical PULMONARY FAILURE Examiner Due to (or as a consequence of): Physician/Medical Examiner sician end burial-transit SIPSIS The law requires that the death certificate be executed Sequentially list conditions, if eny, leeding to immadiata cause. Enter Underlying Cause (Disaase or injury Due to (or as a consequence of): Box 68760. attending physician for use as the bune PORFORATION ESOPHAGNAL thet initieted events resulting in deeth) Lest Due to (or as a consequence of): P.O. 1 signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, þ cata hes been sig 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy 1 Yes 20 No 1 ☐ Yes 2 ☐ No cartificata Division of Vital Hospital or Attanding Physician: 3 24 hours aftar death. Funeral Director: Aftar this cartifica ately filled in by tha funaral director, p. 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: Inpatient 2 ER/Outpatient 3 DOA Medical Certification: To 27. Manger of Death 28a. Date of tnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accidant 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, Stata) 28e. Place of Injury - At home, larm, street, factory, office building, atc. (Specify) 4 Homicida To the Hospital or within 24 hours aft To the Funeral Di complately filled in Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of axamination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Certifier

State Registrar

JUL 1 4 2000

29b. Signeture end title of certifier

COLLUNE 32. Registrar's Signatur

aluer MD

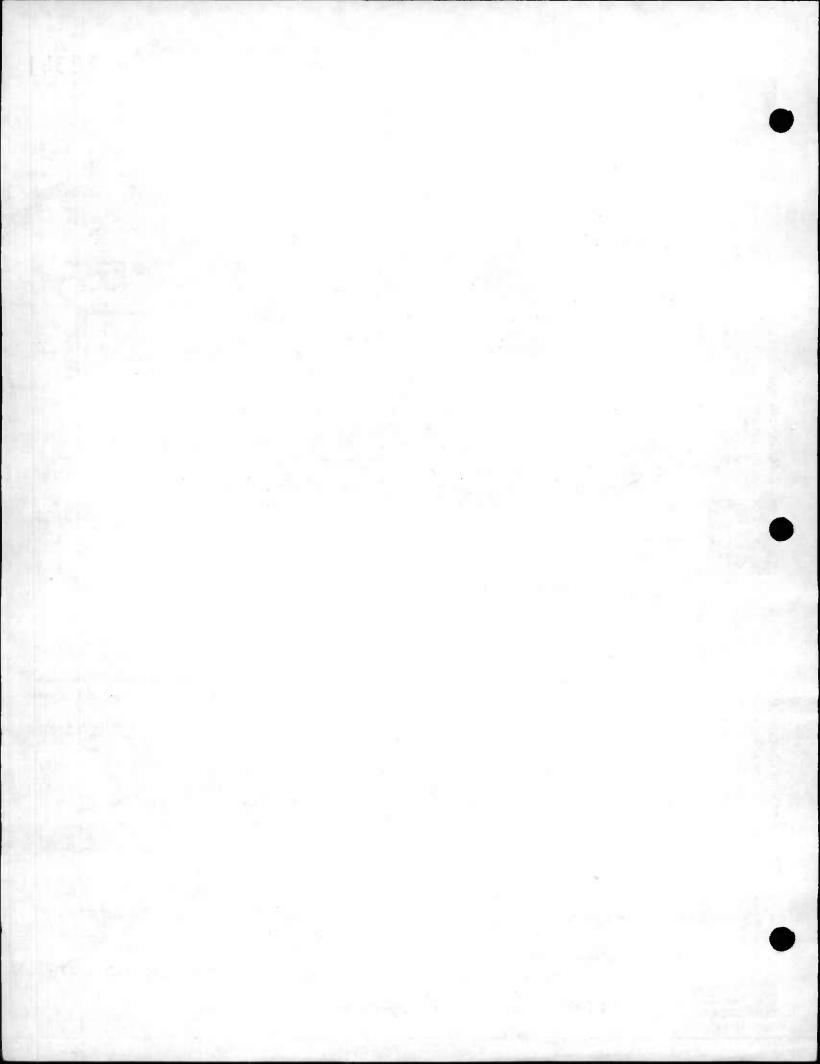
30. Name and addrass of person who completed cause of death (Item 23a) (Type, Print)

29c. License number

250590

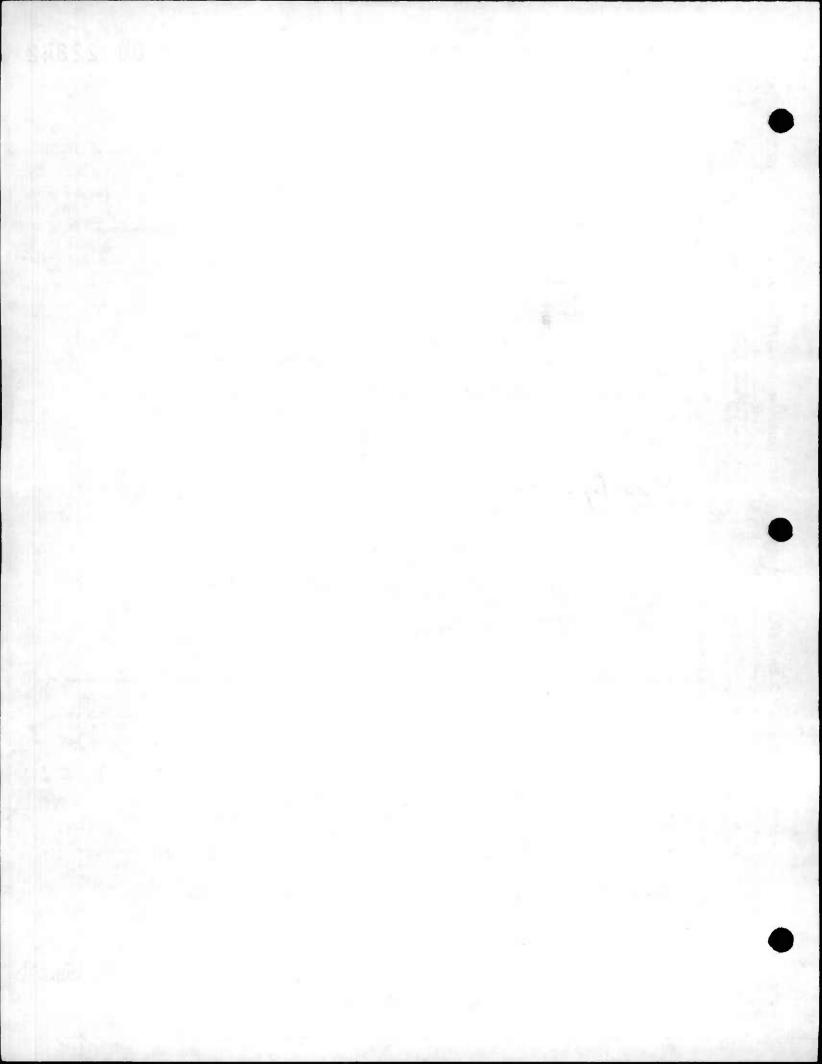
M.D. 22 S. Greau St. ZIto. MD 21230

29d. Date signed (Month, Day, Year)



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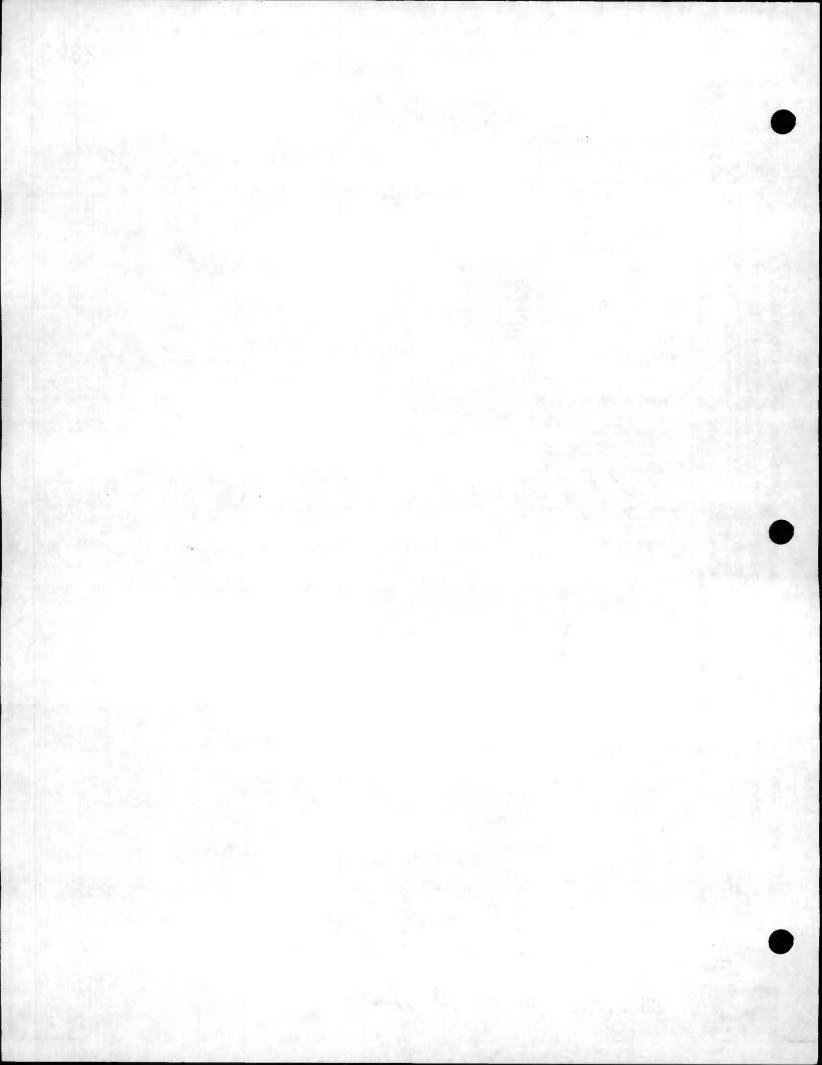
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h the	Director	Maryland 10e. Street and Num	How	rail0	1	10f. Zip		olumbia		10g. Citizen of V	Vhat Country?
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15-002 n 72 hours "natural", c	b		15. Decedent's Edi		164	. Decedent's Usua	l Occur	netion		16b Kind of Bu	White usiness/Industry
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arylan should be and Mentel marked o	2		Samuel	D. Bare					На	ttie Young	
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Baltimol permit. Pages Department of important: If it any injury or of		4 ☐ Donation 21. Signature of Fur	5 Olhar (Specify		All Cou	nty Crematio		VICES, IIIC.	7/14/00	Sykes	ville, Maryland
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State of Maryland / Department of Health and Mental Hygiene 00 22343

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		1523 Florida Social Security Number			Ann the co		Lateral B	ff Under 1 Ye		rern er 24 Hrs.	8. Dete of Bir			rundel
ral tor		214-56-1608	6. Se	XM 2□F	46 Age (In y			Months Da			Dec. 1	ey, Year)	C	rthplace (State or F country) aryland
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State of Maryland / Department of Health and Mental Hygiene [] [] Judy Lynn Bowles AMEND ITEMS: #23 PART I, 27, 28A-F PER MEO Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Judy Lynn Bowles 06 2000 05:40 A.M. July /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Examiner

Train track @ Nebel Street & Randolph Road 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 5. Social Security Number

31

1 M 210 F

Rockville

Montgomery 8. Date of Birth (Month, Day, Year) June 16,1969 9. Birthplace (State or Foreign Country) West Virginia

10d. Inside City Limits

1 Yes 2 No

Funeral Director

Items 23s or 25s-f

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Department of I

Maryland 21215-0020

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Completed

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edical Certification: To

10a. State 10b. County Md. Montgomery 10c. City, Town or Location Silver Springs

Yrs.

10e. Street and Number

11 Maritai Status

138-68-1453

Usual Residence of Decedent

3935 Lantern Lane

20902 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

Hours

14. Raca - Americen Indian, Black, White, etc.

1 Nevar Married 2 Married 3 ☐ Widowed 4 ☐ Divorced

12. Was Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 No If Yas, Give lf Yas, Give Year or Dates: 15. Decedent's Education (Specify only highest grade completed)

1 Yes 2 No Specify: 16s. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)

Days

Specify: White 16b. Kind of Business/Industry

10g. Citizen of What Country?

U.S.A.

Elementary/Secondary (0-12)

Collega (1-4or 5+)

Computer Analyst

10f. Zip Code

Market Research

17. Father's Name (First, Middle, Last)

Alvin Otis Bowles, Jr.

18. Mother's Name (First, Middle, Maidan Sumama) Patricia Ann Shinners

Date

19a. Informant's Name/Relationship (Type, Print)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Coda) 4114 Walnut Pond Drive, Houston, Texas 77059

Eckhardt Funeral Chapel

Alvin O. Bowles, Jr. - Father 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

20b. Place of Disposition (Name of cemetery, crematory or other place)

20c. Location - City or Town, Stata Baltimore, Md.

4 ☐ Donation 5 ☐ Other (Specify)

Metro Crematory July 14, 2000 22. Nama and Address of Facility

Service Licenses

11605 Reisterstown Rd., Owings Mills, Md. 23a. Part1. Enter tije disease, or complications that ceused the death. Do not antar tha mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one ceuse on each line.

Approximata Intervel Between Onset end Death

Physician /Medical Examiner

and

physician

the

980 for

2

page 2 certificate hes

director.

this funeral

After

I Director: Aff

Immediate Cause (Final disease or condition resulting in death)

MULTIPLE INJURIES

Due to (or as a consequence of):

Due to (or as a consequence of):

Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Due to (or as a consequenca of):

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy performed?

24b. Were autopsy findings availabla prior to completion of ceuse of deeth?

1 Yes

1 Yes 2 No

25. Was case referred to medicat examiner? 1 XYes 2 No 27 Mannar of Death

28a. Dete of Injury (Month, Dey Year) 5 Pending investigation

6XXCould not be determined

1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA A 28b. Time of 5:50

28c. Injury at Work? 1 Yes 2 No

26. Place of Deeth (Check only one)

Other: 4 Nursing Home 5 Residence 6 Other (Specify) Scene 28d. Describe how injury occurred SUBJECT STRUCK BY TRAIN

28e. Place of Injury - At home, farm, street, factory, office building TRACKS

281. Location (Street and Namber of Fural Route Number NEBEL STREET, ROCKVILLE, MD.

29a. Certifier (Check only one)

1 Natural

2 Accident

3 Suicida

4 Homicide

1 Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete end place, and due to the cause(s) and manner stated.

29b. Signature and little of certifier

29c. License number O.C.M.E.

July 7, 2000

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause bi leath (Item 23a) (Type, Print)

HEODO RE 11,11-9 31. Date filed (Month, Day, Year)

111 32. Registrar's Signature

Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

31 2000

ORIGINAL

The lew requires that the death certificate be executed Box 68760. P.O. Records, of Vital Physician: Division or Attending

24 hours To the Hosp within 24 hor To the Fune completely fi

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Alvin J. Dolles, Jr. - Enthe | 411 | Melnut Done Drive, Toucton, Lexan 77059

term will 14, 1800 initiane, c.

c'eset est cond 21117 11605 eist etem ec., in ill, c. Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death Month 3. Time of Death Dey Year **Physician** Russell Martin Boykin 3:31 PM July. 11, 2000 /Medical 4a Fscility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore City N/A Johns Hopkins Bayview Medical Ctr. If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** ¥CKM 2□ F Yrs. 215-16-0963 Director May 27, 1923 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Dunda1k 1 ☐ Yes 2 No Maryland Baltimore Director r 28a-f 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ò 2100 Cameron Drive Apt. 1 A 21222 United States 12. Wes Decedent Ever in U,S. Armed Forces?

1 1 Yes 2 1 No If Yes, Give Year or Detes: Wes Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Bleck, White, etc. 11. Marital Status be filed within 72 hours after de tal Hygiene. d other than "natural", or llem event, the Medical Examiner. 1 ☐ Never Merried 2 ☐ Merried Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify. White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Painter Home Improvement 4 Years permit. Pages 1 and 2 should be file.
Department of Health and Mental Hyg.
Important: If them 27 is marked other
any injury or other trauments other
pages. 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Charles Boykin Mary Gossmann 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bessie Barker (Sister) 2100 Cameron Drive Apt. 1A Dundalk, MD 21222 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete PDBurial 2 ☐ Cremetion 3 ☐ Removel Irom State Crownsville V.A. Cem. 7/14/00 4 ☐ Donation #5 ☐ Other (Specify) Crownsville, MD 22. Name end Address of Fecility
Duda-Ruck Funeral Home of Dundalk, Inc. 21. Signeture of neral Service Licente 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the diverse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Interval Between Onset and Deeth **Physician** Immediate Cause (Finat disease or condition resulting in death) /Medical Myocandial 30 M.14 Examiner Due to (or es a consequence of): Sclenuna Physician/Medical Examin The law requires that the death certificate be axecuted Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): 68760. physician s the buria Due to (or as a consequence of) Box P.O. | Pert It. Other significant conditions contributing to death but not resulting in the underlying cause given in Part It. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown My Snohing hypertansin Records. þ 24b. Were eutopsy lindings available prior to Completed 24a. Wes en eutopsy performed? Increased Chalasteral 1 sectes completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vitai or Attending Physician: 25. Wes case referred to medical examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 | Inpatient 2 | PER/Outpatient 3 | DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 9No After this 27. Manner of Death 28b. Tima of 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28c. tnjury at Work? 1 Netural 5 Pending n 24 hours after death.

The Funeral Director: After pletaly filled in by the fur 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Plece of Injury - At home, larm, street, lectory, office building, etc. (Specify) 4 ☐ Homicide Hospital 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only To the within 2 end title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D36430 address of person who completed cause of death (Item 23a) (Type, Print) Boltina 21222 QUA Dalle 664154 2112 KI CHONOS DA NO 31. Date liled (Month, Day, Year) 32. Registrer's Signeture State JUL 1 4. 2000 Registrar

DHMH 16 Rev 6/95

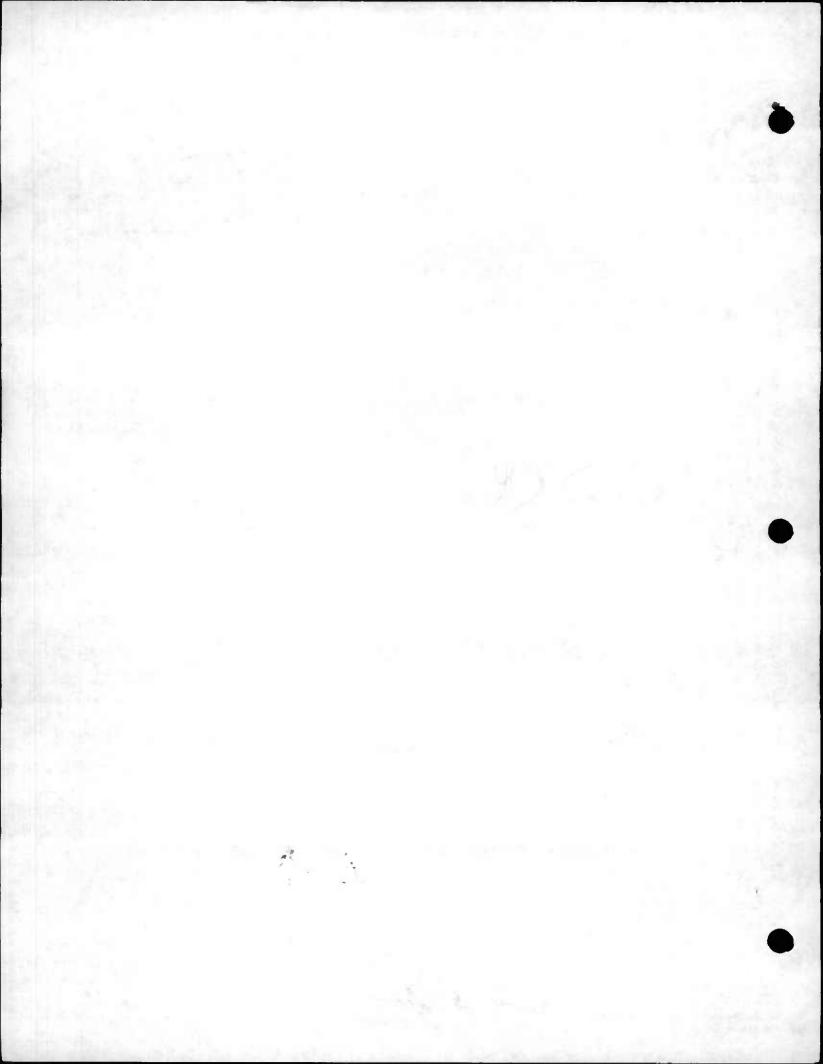
Please Type or Print in Black Indelibie Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 22346 Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death Month Da **Physician** 0420 Robert Albert Barnhart 2000 8 /Medical 4c. County of Death 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death **Examiner** Washington County Hospital Hagerstown Washington If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Birthplace (State or Foreign Country)
 PA 5. Social Security Number 7. Aga (In yrs. last birthday) **Funeral** Months 1 M 2 □ F 164-34-1577 60 September 23,1939 Director Usual Rasidence of Decedent the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ahom r than "natural", or items 23a or 28a-f ahov the Medical Examiner must be notified at 1 ☐ Yas 2 No Funeral Director Fulton Warfordsburg 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? death with 908 Big Cove Road 17267 USA 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedant Evar in U,S. Armed Forces? 14. Rece - American Indian, Black, Whita, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or the ury or other traumatic event, the Medical Examina 1 XYas 2 No If Yas, Giva 1 Nevar Married 2 Married 21215-0020 Specify: White 1 ☐ Yas 2 X No Specify: þ 3 Widowed 4 Divorced Yaar or Datas: Be Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) Inspector State Government Baltimore, Maryland 17. Father's Nema (First, Middla, Last) 18. Mothar's Name (First, Middla, Meidan Surnama) Albert Barnhart Evelyn Faith 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) 19a. Informent's Name/Ralationship (Type, Print) 908 Big Cove Road Warfordsburg, PA 17267 Barbara J. Barnhart/Wife 20b. Place of Disposition (Nama of camatary, cremetory or other pleca) 20c. Location - City or Town, Stata 20e. Mathod of Disposition Data 1 Burial 2 □ Cramation 3 □ Ramovel from Stata Department of Important: If any Injury or □ Donation 5 □ Other (Specify) Warfordsburg Presbyterian 07/11/2000 Warfordsburg, PA Grove Funeral Home, P.A. 21. Signature o Funeral Service License 141 W.Main St.Hancock, MD 21750-0368 23a. Pert1. Enter the diseese, or complications ahock, or heart feilure. List only one ceuse caused the deeth. Do not anter the mode of dying, such as cardiac or respiretory arrest, each line. Approximata inlarval Batween Onset and Daath **Physician** /Medical Immediata Causa (Final disaasa or condition rasulting in death) Examiner Meloge Physician/Medical Examiner Sequentially list conditions, if any, leading to immadiata cause. Entar Undarfying Ceuse (Disease or injury that initieted evants rasulting in death) Last Box 68760 Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use copfribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown Vital Records, Completed by 24e. Wes an autopsy performad? 24b. Wara eutopsy findings available prior to complation of cause of death? certificate has 1 Yas 21 No 1 Yes 2 No 25. Was case raferred to medical axaminar? Medical Certification: To Be 26. Placa of Death (Check only ona) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 100 1 Inpatient 2 ER/Outpatient 3 DOA to PIS. 27. Mannar of Death 28a. Data of Injury (Month, Day Year) 28b. Tima of 28c. injury at Work? 28d. Dascribe how injury occurred Affer Division 1 Netural 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be detarmined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicida 28a. Placa of Injury - At homa, farm, straat, factory, offica building, atc. (Specify) 4 I Homicide 8 To the Hospital within 24 hours of To the Funeral 29a, Cartifier Certifying Phyeician: To the best of my knowledge, death occurred at the time, date and plece, end due to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination end/or investigetion, in my opinion, death occurred at the time, date end place, end due to the ceusa(s) and manner stated. 29d. Data signed (Month, Day, Year) 29b. Signatur 8 State Registrar

DHMH 16 Rev 6/95

Barnhout



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22347 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month Year Frank L. Cordier, Sr. JULY 1705 2000 08 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death ITEALTH (AME BALTIMONE ALNES If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) If Under 1 Year Birthplaca (State or Foreign Country) New York 5. Social Security Number 7. Age (In yrs. last birthdey) Months Days 1 M 2□ F 74 Yrs. 074-18-8426 Aug. Usual Residenca of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes & ☐ No Baltimore Catonsville 10e Street and Number 10f. Zin Code 10g. Citizen of What Country? 21228 I-E MacIntosh Court 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ∰ Yes 2 ☐ No If Yes, Give Yaar or Dates: 1 Never Married 2 Married White 1 Yas 2 No Specify: Specify. 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Manufacturing Maintenance 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfreda Loether Charles Cordier 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3 hillside Drive, Lake City, Florida 32025 Frank L. Cordier, Jr./Son 20b. Placa of Disposition (Name of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 🐰 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/12/00 Elkridge, Maryland Meadowridge Memorial Prk 22. Name and Address of Facility Witzke Funeral Homes, Inc. 21. Signature of Funeral Sarvice Licenses 1100741 1630 Edmondson Avenue, Catonsville, MD 21228 Stande Lemmer 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 17040 OMISA FAZLULE disease or condition resulting in death) Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): EUMONZA Due to (or as a consequenca of) 23b. Did tobacco use contributa to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy tindings available prior to complation of causa of death? 24a. Was an autopsy performed? 2 No 1 Yas 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpetient 2 □ ER/Outpatient 3 □ DOA 27. Manper of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. tnjury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yas 2 No 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, State)

The law requires that the death certificate be executed P.O. Box 68760 Vital Hospital or Attending Physicien: Division of

Physician

/Medical

Examiner

Funeral

Director

Mode

Director

Funeral

λq

Completed

12

them 27 is marked other than "natural", or flams 23a or 28a-f ahos other traumatic event, the Medical Examiner must be notified at

Il Hygiene.

Department of Health and Mental Important: If Nem 27 is marked or any Injury or other traumatic eve Pages 1 and 2 should be

Physician' /Medical

Examiner

thet

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certificate has page 2

death.

after death Director: filled in by the Physician/Medical Examiner

Completed by

Be

3 ☐ Suicide

29a. Certifier

4 | Homicide

29b. Signature and title of certifier

with the Meryland

filed within 72 hours after

Maryland 21215-0020

Baltimore,

within 24 hours a To the Funeral C completely To the

Medicai Certification: To

Registrar DHMH 16 Rev 6/95

28e. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify)

29c. License number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as staled.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

CATON

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print) RODME

6 Could not be determined

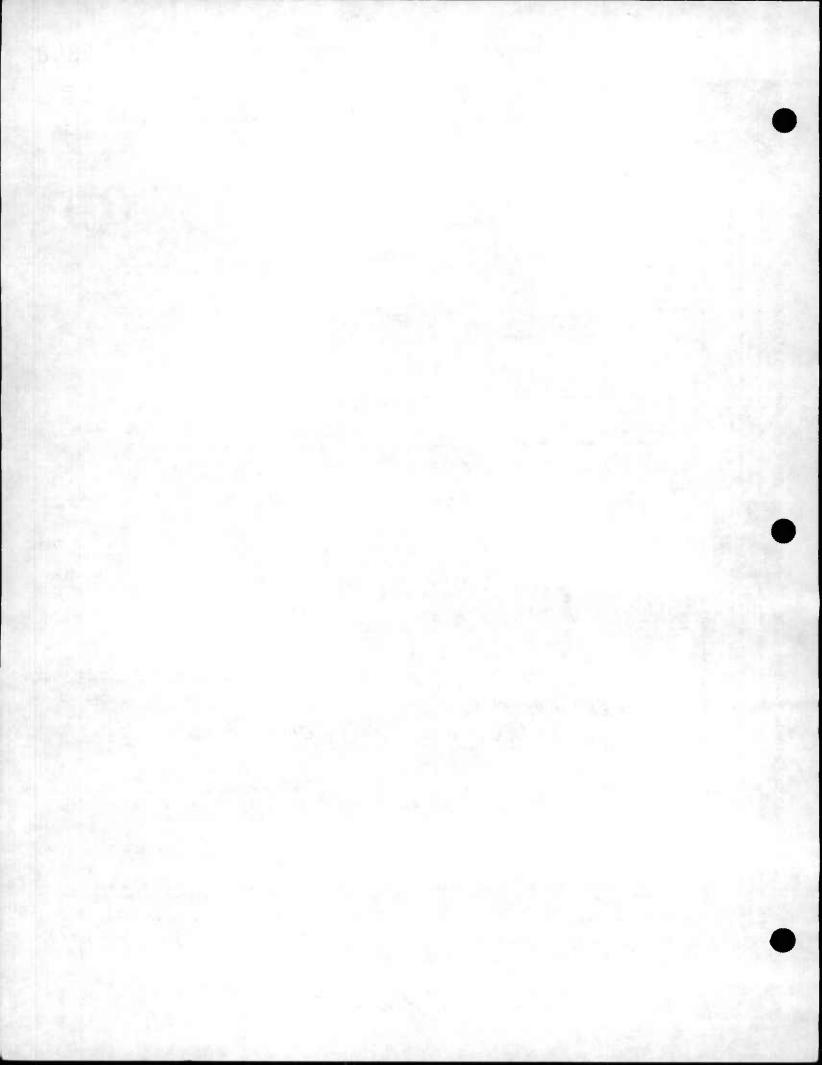
man 31. Data filed (Month, Day, Year) 32. Registrar's Signature

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00

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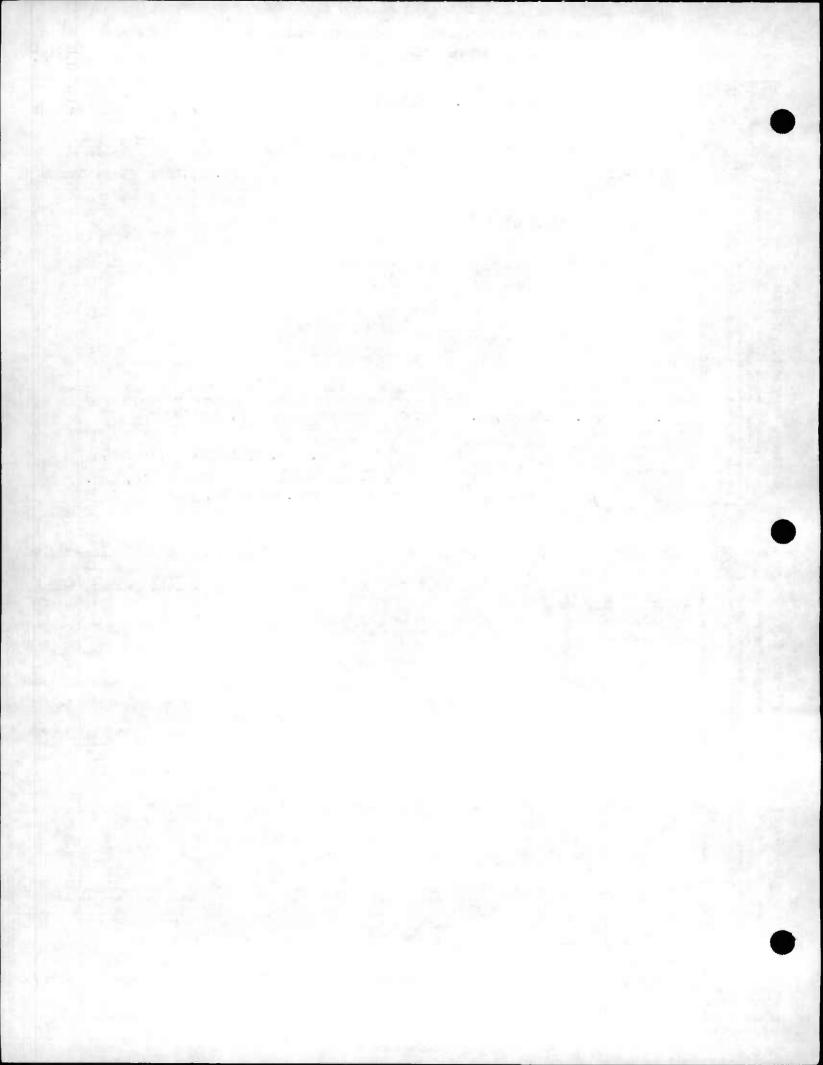
				Cer	tificate d	of Death	7		Reg. No.		
Physician	1. Decedent's Name (First, Midd	le, Last)						2. Date of De Month	Day	Year	3. Time of Death
/Medical	Adella				Car	ver			10, 200		7:25 PM
Examiner	4a Facility Name (If not institution 3004 North Richards)					Ellic	ott		Н	oward	County
Funeral Director	5. Social Security Number 217-07-5940	6. Sex 1 □ M 2 X F	7. Age (In yrs. last 95	birthdey) Yrs.	If Under 1 Ye		r 24 Hrs. Min.	8. Date of Bir (Month, Di Jan. 21	1905	9. Births Mary	lace (State or Foreign
14	Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Loc	ation					1	0d. Inside City Limits
items 23e or 28e-f ahow me must be notified at uneral Director	MD Howa			cott	City						1 □ Yes 2X No
r tems 23s or 28s-fanithment must be notified Funeral Director	3004 North Rid	lge Road- A	pt. 329		10f. Zip Coo 2104				U.S.A.	Whet Cour	ntry?
2 = -	11. Marital Status 1 Never Married 2 Mar 3 X Widowed 4 Divorced	ried 1 Yes	2 1 No		/as Decedent Yes, specify (ecify Yes or No Rican, etc.)	14. Rad Bla Specif	ca - Americ ck, White,	
Apparament or beeth and Montal Hygiene. Important: If fem 27 is marked other than "natural", eny injury or other traumatic event, the Medical Enemones. To Be Completed by	15. Deceder (Specify only higher Elementary/Secondary (0-12)	nt's Education st grade completed)		(Give A	ent's Usuel Oc lind of work do O NOT use re Iminist	ne during mo tired)	st of worki	ing			evenue
Opportunity of them 27 is marked other than may injury or other traumatic event, the Manages. To Be Compi	17. Father's Name (First, Middle, Hervey G. Fot		94		J.			(First, Middle Bauer	, Maiden Sumar		
27 la ma er trauma	19e. Informant's Neme/Reletions Mrs. Dorothy								e, Maryl		
rt: If flem iry or oth	20a. Method of Disposition 1 Durial 2 Cremation 4 Donation 5 Other (S		cam	etery, crem	etory or other Cemete	place)	7	Date /14/00	20c. Location Woodla	111111111111	own, State laryland
importa eny inju	21. Signature of Funeral Service	Licensee Heath	er Cain		Name and Ad		Ba		,Maryla		
	23a. Part1. Enter the disease, o	r complications that ca	used the death. (305 Har	Tora	Approximate
ysician Medical	shock, or heart failure. List Immediate Ceuse (Final	only one cause on ea			•						Interval Between Onset and Deeth
aminer	disease or condition resulting in death)	8.	DEM T	a consequ	uenca of):	pro	6 R 171	STUR		1	Y FRAL
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	resulting in usatify cast	d								1	P. 15.
the attended for	Pert II. Other significant condition	ons contributing to de	ath but not resultin	g in the un	derlying cause	given in Par	1.	23b. Did	tobacco uss co	ontributa t	o the cause of death'
igned by the atter be detached for the by Physicial	OSTE	To ponus	515			100		10	Y 2 2 No	3 ☐ Pro	bably 4 Unknow
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page Com								10	Yes 20 No	1	☐ Yes 2☐ No
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State of Maryland / Department of Health and Mental Hygiene 00 22349

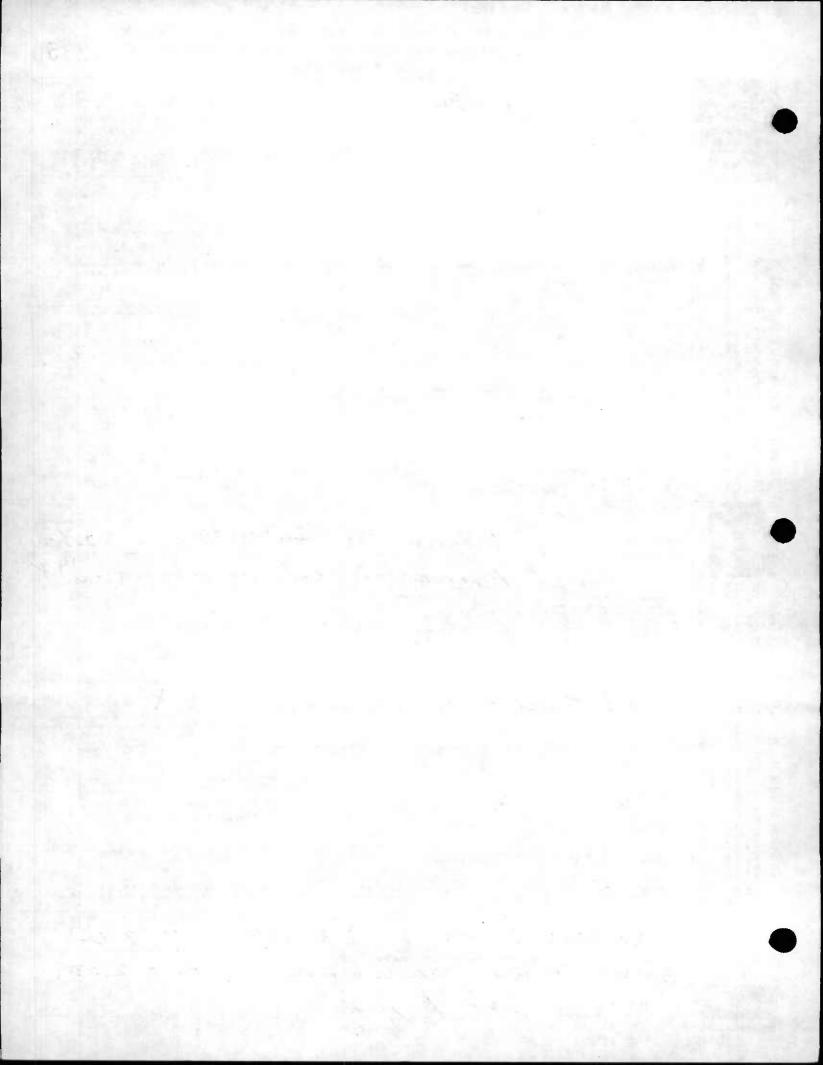
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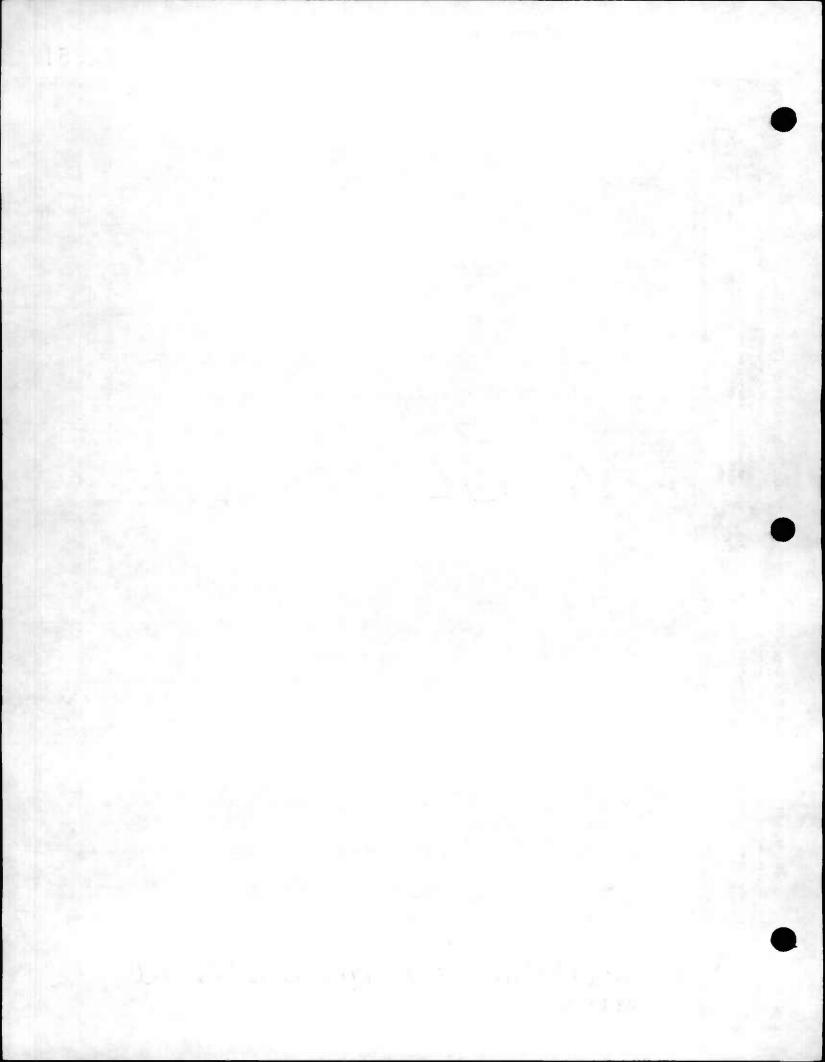
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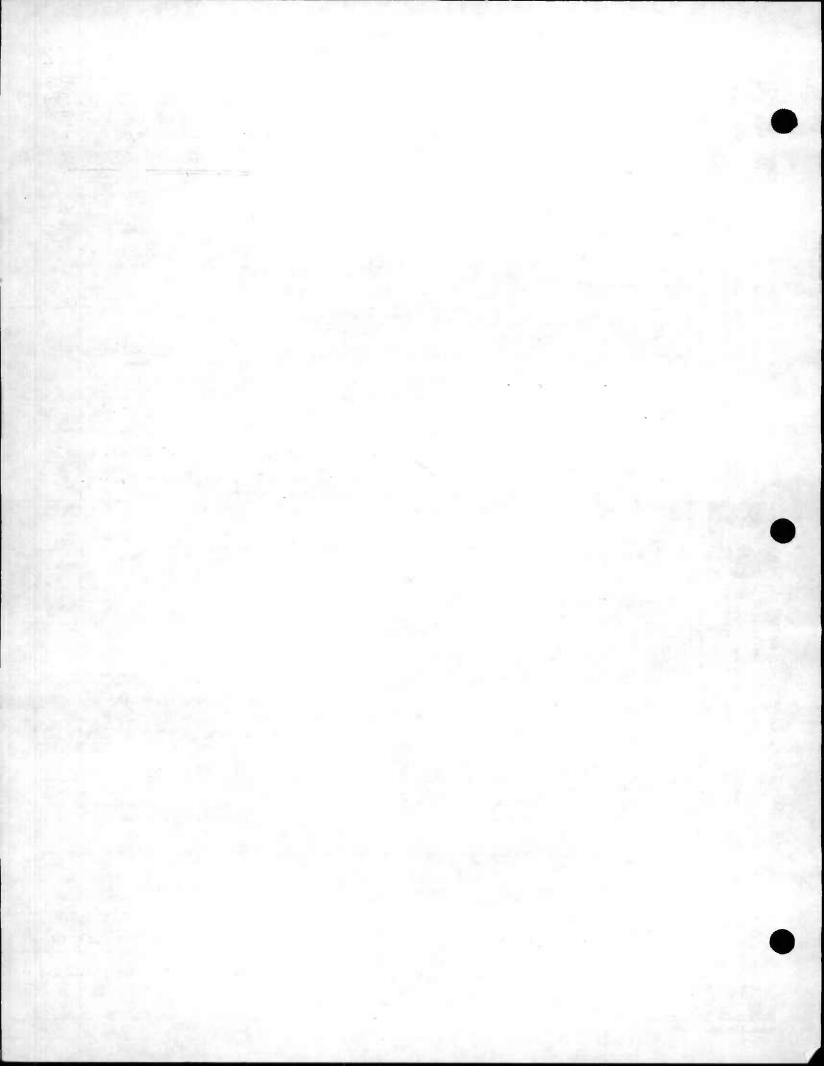
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | AMEND#8&9 PER F.H. G785 7-25-2000 JAB Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Deeth 3. Time of Death 2:54 PM **Physician** DAVID DENHAM 8th 2000 JULY /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death Examiner Bayview Medical Center - Johns Hopkins Baltimore Hours Min. 8. Dete of Birth 2–27–15 7. Age (In yrs. last birthday) If Under 1 Year Months Days 5. Social Security Number 9. Birthplece (State or Foreign Country) PFNNSYLVANIA 6 Sax **Funeral** Days 1 M 2 □ F Yrs. 85 Director 213-09-4028 Ecb. 15,1915 Usuel Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified as 1 Yes 2K No Edgemere Baltimore Director Maryland 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? 21219 United States 7723 North Cove Road 14. Raca - American Indien, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Spacify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) e filed within 72 hours after al Hygiene. other than "natural", or the 1 Yes 2 No If Yes, Give Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried altimore, Maryland 21215-0020 1 Yes XXNo Specify: þ 3 Widowed 4 Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usuai Occupation (Give kind of work done duning most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Steel Industry Steelworker 12 Years permit. Peges 1 and 2 should be fits.
Department of Heelth and Mental Hy Important: If item 27 is marked other any injury or other treumetic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be David E. Denham, Sr. Jane Rodgers Bell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informent's Name/Relationship (Type, Print) 7723 North Cove Road Edgemere, Maryland Mrs. Anna May Denham (Wife) 20b. Placa of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from Stete Lawn Cemetery 7/11/2000 Baltimore, Maryland 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of F uneral Service License 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final Anterior Myocardial Infarction. disease or condition resulting in death) **Examiner** Due to (or as a consequenca of): Examiner Pulmonary Edema Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. 99 Physician/Medical Due to (or as a consequence of): P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Hypertension Division of Vital Records, p 24b. Were autopsy findings available prior to completion of cause of death? Completed 24e. Wes an autopsy Diabetes. Cerebrovascular Accidents. 1 TYes 2 No 1 Yes 2 No 25. Wes case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of or Attending F ster death. Director: After 1 Metural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide To the Hospital o within 24 hours of To the Funeral Di completely filled in 1Decertifying Physician: To the best of my knowledge, death occurred at the time, date and piaca, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and piece, end due to the cause(s) and manner stated. Medical (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 20303 dua MI July 8th 2000 Laram 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue Battimore, Maryland 21224. Param Dedhla, M.D. 31. Dete filed (Month, Day, Year) 32. Registrár's Signature

DHMH 16 Rsv 6/95

Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 2. Data of Daath 3. Tima of Death 1. Decedant's Nama (First, Middla, Last) Year 10:00 A.M Juh 13 2000 MARTHA JANE **EVANS** 4b. City, Town, or Location of Baath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death NORTH ARUNDEL HOSPITAL ASSOCIATION ANNE ARUNDEL GLEN BURNIE If Undar 1 Yaar If Undar 24 Hrs. 7. Age (In yrs. last birthday) 5. Social Sacurity Number 8. Data of Birth (Month, Day, Yaar) Birthplaca (Stata or Foraign Country) Months Days Hours 1 M 20 F 81 KENTUCKY 403-38-1623 OCT. 25, 1918 Usual Rasidance of Deceden 10d. Insida City Limits 10c. City, Town or Location 10b. County 1 Yas 2 No GLEN BURNIE MARYLAND ANNE ARUNDEL 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Coda 100 FERNDALE AVENUE u.s.a. 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - Amarican Indian, Black, Whita, etc. 12. Was Decedant Evar in U,S. Armed Forcas? 11. Marital Status 1 ☐ Yas XXNo If Yas, Giva 1 Navar Marriad 2 Married 1 Yas 2 No Specify: Specify: WHITE 3 Widowed 4 □ Divorced Yaar or Datas: 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elamantary/Secondary (0-12) Collega (1-4or 5+) 8 HOMEMAKER OWN HOME

McGUIRE

of person who complated cause of death (Itam 23e) (Type, Print)
WESLEY . 301 Hospital Dec

#32. Ragistrar's Signature

brejun1

31. Data filed (Month, Day, Year)

19e. Informant's Name/Relationship (Type, Print) (DAUGHTER) 19b. Mailing Addrass (Straat and Number or Rural Routa Number, City or Town, Stata, Zip Code)

cematary, crematory or othar place)

STONE CHURCH CEMETERY

20b. Placa of Disposition (Nama of

18. Mothar's Nama (First, Middla, Maiden Sumama)

BURNETT

20c. Location - City or Town, Stata

ENOLA, PENNSYLVANIA

2000

2106/

ZORA

100 FERNDALE AVENUE, GLEN BURNIE, MD. 21061

alen Bueno.

2000

22. Nama and Address of FacilitSINGLETON FUNERAL HOME, P.A., 1 SECOND AVENUE, S.W., GLEN BURNIE, MD. 21061

is 23a or 28a-f show must be notified at Directo Funeral altimore, Maryland 21215-0020 by Completed Be Pages 1 and 2 should be 2

Physician

/Medical

Examiner

10a. Steta

ROBERT

20a. Mathod of Disposition

17. Fathar's Nama (First, Middla, Last)

MRS. RUBY JEAN CRACE-HART

1 Burial 2 Cramation 3 Removal from State
4 Donation Char (Specify)

Funeral

Director

Physician /Medical Examiner

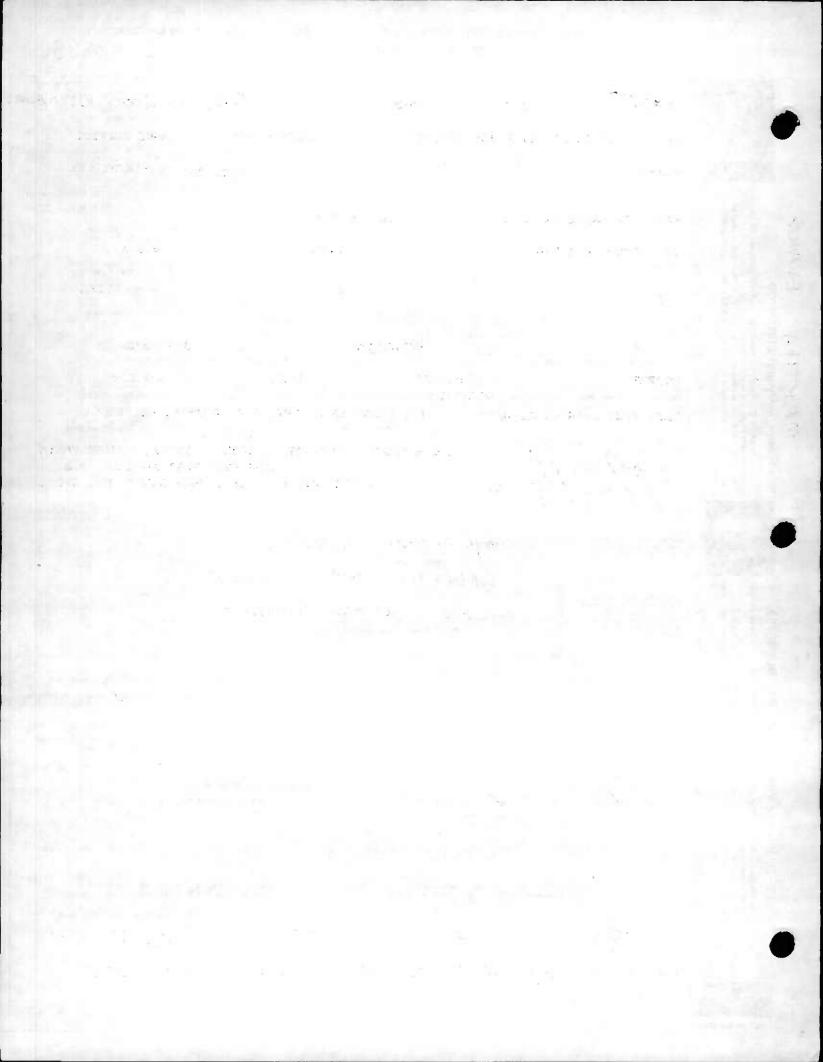
attending physician and for usa as the burial-transit requires that the death certificate be executed signed by the a page 2 s cartificata has To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this cartifical completely filled in by the funeral director,

Division of Vital Records, P.O. Box 68760.

23a Part1. Enter the disease, or oby	flications that causad tha daa ona causa on aach lina.	th. Do not entar the mo	da of dying, such as cardie	oc or respiratory arrast,	Approximata Interval Batwaan Onsat and Death
Immediata Causa (Final disaasa or condition resulting in death)	· myoca	201AL	INFARCTION	7	
Sequantially list conditions, if eny, leading to immediate causa. Entar Undarlying Causa (Disease or Injury	b. CONDE	or as a consequence of	EART FA	ruste Let	
that initiated events rasulting in death) Last	U	or as a consequance of)			
Part II. Other significant conditions of	ontributing to death but not re-	sulting in tha undarlying	cause given in Pert I.	23b. Did tobecco use co	ntribute to the couse of death
				24a. Was an autopsy performad?	24b. Ware autopsy findings availabla prior to completion of causa of death?
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25. Wes case referred to medical axaminer? 1 ☐ Yas 2 ☑ No	Hospital: Inpatient 2	ER/Outpatient 3□ D		aath <i>(Check only one)</i> Homa 5 ☐ Rasidance 6 ☐ Oth	Constal
27. Menurer of Deeth NZ Natural 5 Panding 2 Accidant Invastigatio	28a. Data of Injury (Month, Day Year)	28b. Tima of Injury M	28c. injury at Work? 1 Yas 2 No	28d. Dascribe how Injury occur	
3 Suicida 6 Could not be datamined	28a. Place of Injury - Ath building, atc. (Space	oma, farm, straat, fectory)	ry, office	28f. Location (Streat and Numb City or Town, Stata)	ber or Rurel Routa Number,
				se, and dua to the ceuse(s) and mourred et the time, date and place,	
29b. Signatura and titla of certifier		25	c. Licansa number	29d. Data signa	ed (Month, Day, Yaar)

State Registrar



inter death with the Menyland reference 23e or 28e-f above river must be notified at Funeral Director	10e. Street and Number 20/7 11. Maritel Stetus	altimore S 12. Was Decedent Ever in U.S. Armed Forces?	13. Wes Decedent	of Hispenic Origin? (S Cuben, Mexican, Puert	pecify Yes or No-	n of What Country? Rece - American Indian, Bleck, White, etc.
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of Heal	20e. Method of Disposition 1 Burlel 2 Cremetion 3 I 4 Donation 5 Other (Speci	Removel from Stete	3031 Br e of Disposition (Name of every, crematory or other	ighton place)	St. Balt Date 20c. Local	tion - City or Town, Stete
permit. Pag Department Important: it any injury o	21. Signatifie of Funeral Service Bios	L. Russ	22. Name end Ad Joseph ZZZZ W	L. Rus	SS Funera Ave. Balt	al Home on Md. 21216
Physician /Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	a	OTIC INTOXIC se consequence of):		or respiretory arrest,	Approximete Intervel Between Onset and Deeth
axecuted in and justice transit Examiner	Sequentially list conditions, if any, leading to immediate	b Due to (or ea	a consequence of):			
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ficata has been signer, page 2 should be d	OF Was seen referred to modifical				11⊠Yes 2□1	No 1 ☐ Yes 200 No
To the Funeral Director. After this certificate has been si completely filled in by the funeral director, page 2 should Medical Certification: To Be Completed	25. Wes case referred to medical examiner? 1 □∰es 2 □ No	Hospitel: 1 Xinpatient 2 ER	/Outpatient 3□ DOA	Other	ith (Check only one) ome 5□ Residence 8 [

State Registrar

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MACY G. PILE, M., 1111 Penn Street, Baltimore, Maryland 21201

31. Dete filed (Month, Day, Year)

32. Registrer's Signature

4. Aparls

O.C.M.E.

JULY 03,2000

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) Month Year Physician 031 Freeman TJI. 9000 /Medical 4b. City, Town, or Location of Deeth 4c. County of Deeth 4a Facility Neme (If pot institution, give street and number) Examiner MUNTI MORE CIT If Under 7. Age (In yrs. last by 8. Dete of Birth (Month, Day) Birthplece (State or Foreign Country) 5. Sociel Security Number **Funeral** Hours Months Deys 1 ♥ M 2 □ F 59 256-54-6818 Ga Director Usual Residence of Decedent filed within 72 hours after death with the Meryland 10s. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 □ No Director Baltimore permit. Peges 1 and 2 should be filed within 72 hours after death with the M. Department of Health and Mentel Pylgiene. Introprient: If them 27 is marked other than "natural", or ferme 23e or 28e-4 introportant: If them 27 is marked other than "natural", or items 23e or 28e-4 any follury or other traumatic event, the Medical Exercities must be noticed. 10e Street and Number 10g. Citizen of What Country? 10f Zin Code 21213 US 1804 Rutland A Funeral Avenue 14. Raca - American Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Maritei Stetus 1 Never Merried 2 Merried 1 Yes, Give No Specify: Black 21215-0020 1 Yes 2 No Specify. þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Unk Elementery/Secondery (0-12) Coilege (1-4or 5+) N/A Crane Operater 11th grade Baltimore, Maryland 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be 0 William Freeman Alene Jones 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Lucky Freeman, Jr- Son 401 N. Airport Drive Highland Springs, Va 23075 20b. Pieca of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition Dete 1 N Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) King Memorial Park 7-15-00 Randallstown, Md 21. Signeture of Funerel Service License 22. Name and Address of Facility
March F/H West 4300 Wabash Avenue Baltimore, Md 21215 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. **Physician** /Medical Immediate Cause (Final disease or condition resulting in deeth) Examiner teomyelitic Examiner The lew requires that the death certificate be executed attending physician and for use as the bunal-trans Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): inheres P.O. Box 68760 Physician/Medical Due to (or es a consequenca of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 200No 3 Probably 4 Unknown vosidar disease Records. þ 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24e. Was an autopsy performed? Completed hes 2 No 1 Yes 2 No 1 Yes Division of Vital 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Yes 2 No 1 Inpatient edical Certification: To 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of 28c. Injury et Work? 28d. Describe how injury occurred Affer 1 Netural
2 Accident Hospital or Attending 5 Pending investigation 1 Yes 2 No death. Director:

within 24 hours a To the Funeral C completely filled

after

State Registrar 6 Could not be determined

30 Name and address of person who completed cause of death (Item 23a) (Type, Print)

MI

601 North

32. Registrar's Signeture

3 Suicide

29a. Certifier

Sak

4 T Homicide

29b. Signeture and title of certified

31. Dete file (Marth, Pey Year)

Cadoline

1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end pieca, end due to the ceuse(s) end menner es stated.

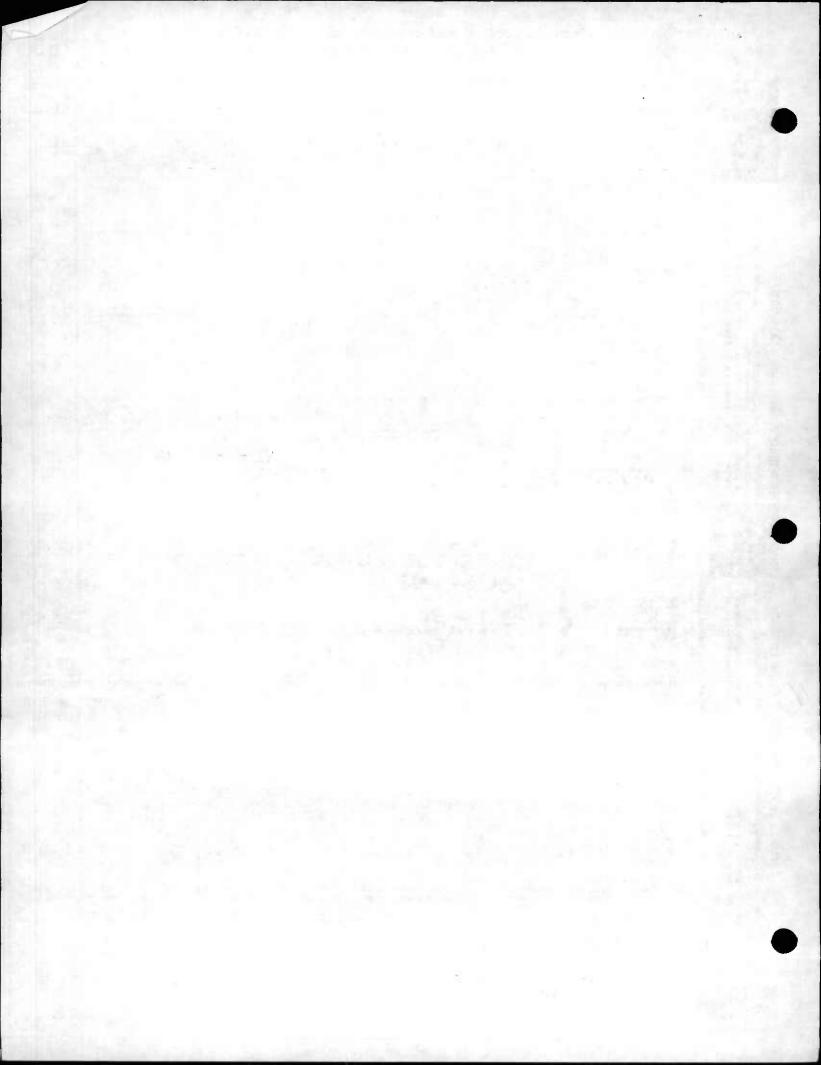
2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, deeth occurred et the time, date end pieca, and due to the ceuse(s) and menner steled.

29c. License number

28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

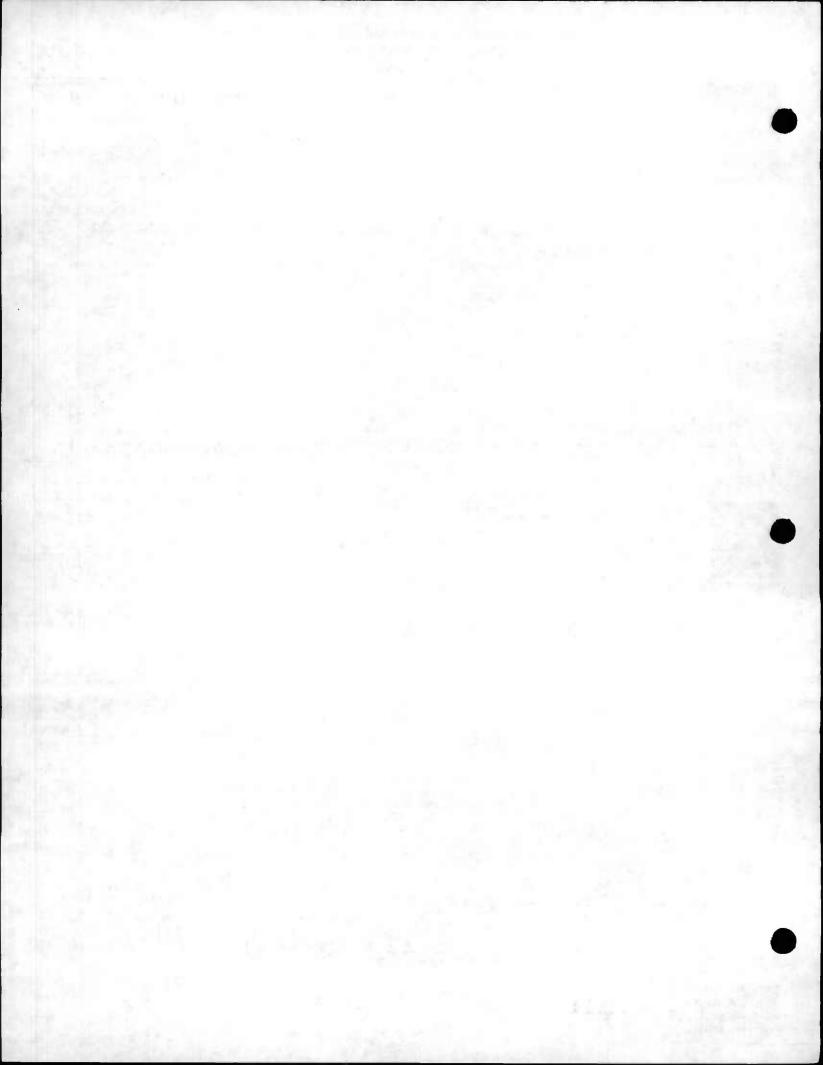
29d. Dete signed (Month, Dev. Year)



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22356

				Cei	rtificate	of I	Death		R	eg. No.		
Physician /Medical	Decedent's Name (First, Midd LEONARD	le, Last)		I	FORMAN	J			2. Date of Deal	11ay 200	O ^{Year}	3. Time of Death 5:14AM
Examiner	4a Facility Neme (If not institution SINAI HOSPITA		imber)	SY			BALT	IMO	cation of Death	4c. County		
Funeral Director	5. Social Security Number 220-01-5749 Usual Residence of Dacedent	6. Sax M 2□ F	7. Age (In yrs. I	last birthday) Yrs.	if Undar	1 Yaar Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Dey NOV • 13	1921	9. Birth Cou M	place (State or Forei ntry) ID
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e 23e or 25e-f sh must be notified. bral Director	10e. Street end Number 7121 PARK HEIGH		903 edent Ever In U.	6 12		215	icagalo Orl	ain? /Sa	ecify Yes or No-		JSA	ntry?
Examiner must Examiner must by Funeral	11. Marital Status 1 Never Married XX Mar 3 Widowed 4 Divorced	ried 1 ☐ Yes	orcas? 2 No ve		lf Yes, speci	ify Cuba	Specify:	, Puarto	Rican, etc.)	Blac	ck, Whita,	atc.
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27 is mar or traumat	19a. Informant's Name/Relations EVELYN FORMAN/		19 - 91						al Route Number #903 B			D. 21215
nert of He int: if Nem iny or othe	20a. Method of Disposition 1 🕅 Burial 2 □ Cremation 4 □ Donetion 5 □ Other (S		C	lace of Dispo emetery, cree EB SHA	matory or of	her plac	a) IAL F	PARK	7/13/00	20c. Location REISTE		
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W.J	DR. JOHN MANN MI	on 10755 I	of deeth (Item			LU	THERV	ILLE	MD.21	093		
State Registrar	31. Date filed (Month, Day, Year, JUL 1 4	32.1	Registrar's Signa	ture /	do	ack	1					



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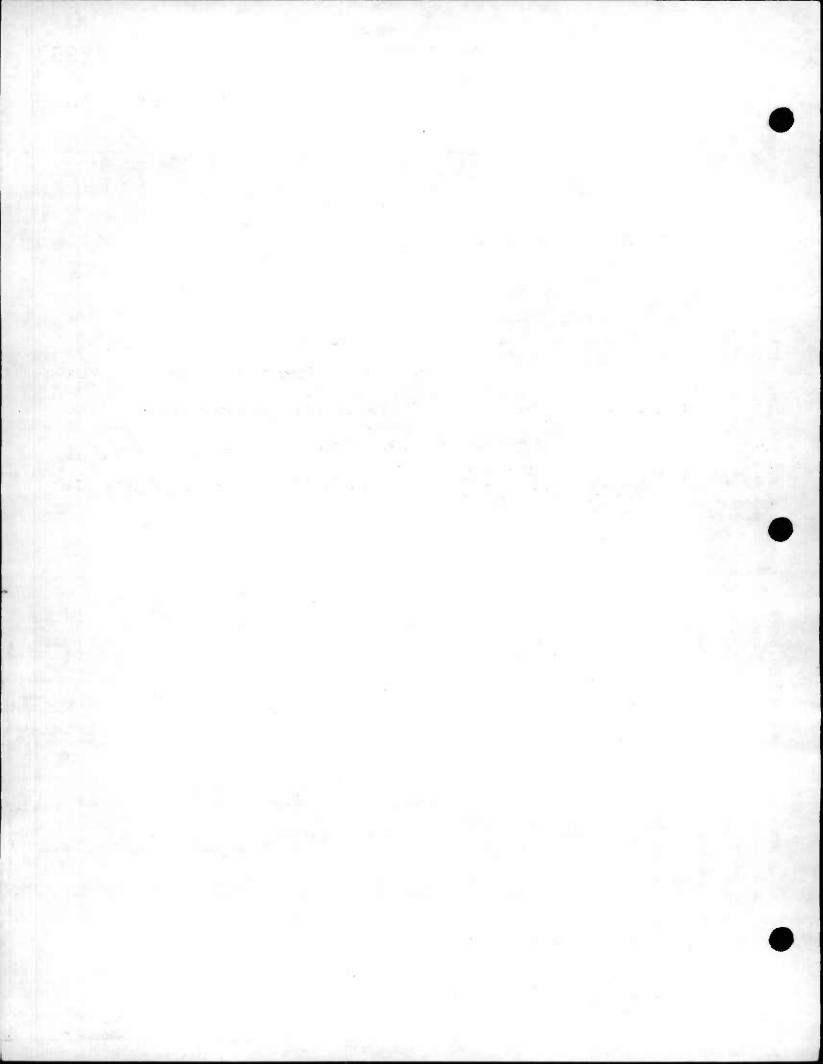
State of Maryland / Department of Health and Mental Hygiene 22357 Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2 Date of Death 3. Time of Death Month **Physician** Mary E. Gauss July 12, 2000 7:25 pm /Medical 4e Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Future Care Canton Harbor Nursing Home Baltimore City 5. Social Security Number 218-03-2008 If Under 1 Year If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) March 2, 1906 Birthplece (State or Foreign Country) 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 20 F Months Days 95 Yrs. Director MD Usual Residence of Decedent death with the Manyland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Hygiene. Ather than "natural", or frems 23s or 28s-f ehow ent, ma Medical Examiner must be notified at Baltimore City MD N/A 1 ☐ Yes 2 ☐ No 10g. Citizen of What Country? 1300 South Ellwood Avenue 10f. Zip Code 21230 United States Funeral 12. Wes Decedent Ever in U,S. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puarto Rican, etc.) 14 Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 20 No Specify: Š White 35 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed will Department of Health and Mental Hyglen Important; if item 27 ie marked other than eny Injury or other traumatic event, man 2008. Homemaker Own Home 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Unknown First Name Frederick (Unknown First Name) Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Clifton F. Gauss, Jr. / Son 1354 Towson Street, Baltimore Maryland 21230 20b. Place of Disposition (Name of cemetery, crematory or other place)

Loudon Park Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 XBurial 2 Cremetion 3 Removal from Stata July 15, 2000 Baltimore 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signeture of Funaral Service LicenseeVictor P. J22. Nama and Address of Facility Doda, Charles L. Stevens Funeral Home, 1501 Fast Fort Avenue, Baltimore Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failura. List only one cause on each line. Approximate Interval Batween Onsat and Death Physician Immediate Cause (Finel disease or condition resulting in death) /Medical 48 Bung BLUFFIRSG FNTRA- ABDOMINAL Examiner Due to (or as a consequence of). Examiner attending physician and I for use as the burial-transit requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): m .. P.O. Box 68760, Physician/Medical Due to (or as a consequence of) USB 08 signed by the aid be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown DEMENTA Records, þ 24b. Wara autopsy findings eveilable prior to completion of cause of death? Completed 24a. Was en autopsy performed? peen : DM page 2 has 1□ Yes 2 No 1 ☐ Yes 2 ☐ No certificate Division of Vital or Attending Physician: director, Be 25. Was case referred to medical axaminar? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After thi 28a. Date of Injury (Month, Day Year) 27. Manger of Death 28d. Describe how injury occurred 28c. Injury at Work? 28b. Time of 1 Naturel 5 Pending efter death. 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 ☐ Sulcide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, ferm, street, fectory, office building, etc. (Specify) • Funeral Hospital 29a. Certifier 10 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and dua to tha cause(s) and mannar as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred et the time, data end placa, end due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) july allighthatoare 13, 2000 216619 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1300 S. ELL WOOD C. VERGARA - SOARES BALTIMORE MD. 21224 32 Registrar's Schature 31. Date filed (Month, Day, Year)

Registra

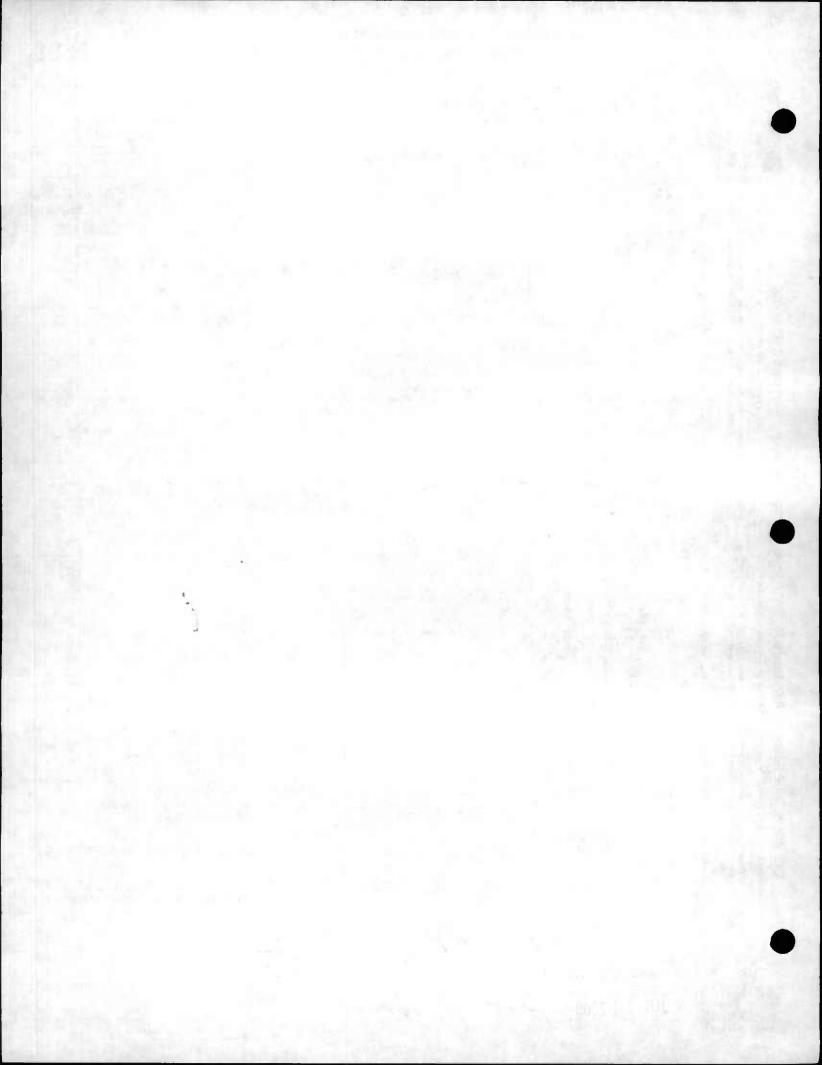
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State of Maryland / Department of Health and Mental Hygiene 00 22358

Facility Neme (If not Institution, ginor Care Nursing Hosel Social Security Number 33-01-7229 Lail Residence of Decedent La. State 10b. County Montgo B. Street and Number 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 15101 Peachstone Date 151	ve street and number) THE Sex TOM 2 F TOVE 12. Was Decedent Armed Forces? 12. Yes 2 If Yes, Give Yeer or Dates: iducation ade completed) College (1-4or 5 2 1)	e (In yrs. last birth 81 Y 10c. City, Town Ever in U.S.	Months or Location Silver 101. 2 13. Was Dec If Yes, sp 1 Yes Decedent's Us Give kind of white. Do NOT	er 1 Year s Days Sprin Cip Code edent of Fecify Cub 202 No sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant of Sprin sual Occupant	20905 Hispanic Originan, Mexican, Specify:	Spring 4 Hrs. 8. Min. M	Date of Birth (Month, Day, Earch 6,	Day 2000 4c. County Man Year) 1919 Og. Citizen of V Uhi 14. Rac Blac	9. Birthold Count 100 Whet Count ted State America	ace (State or Form) W Did. Inside City L BOXYes 2 [Inty? attes In Indian, Ite.
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Signature of Funeral Servica Lice	nsee Victor P.	Doda, Jr.	Charles	L. S	ess of Facility Stevens I	Funera	1 Hame,	Inc. Maryland	212	30
23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heeft feilure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or es a consequenca of):									Approximate Intervel Betwee Onset and Dea	
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of): Due to (or as e consequence of):										
t II. Other significant conditions	contributing to death be	ut not resulting In	the underlying	cause gi	ven in Part I.		23b. Did to	bacco use co	ntribute to	the cause of d
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b. Signature and title offertifier	y y May	MI	2			60	2			
Name end eddress of person who	completed cause of d	eeth (Item 23a) (T		el Mar	yland 2	20707	1959		1	
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Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to 1 Yes 2 No 3 Prob



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 11, 2000 Year **Physician** Thelma E. Griffin 0117 AM /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Edmunds Way Essex Baltimore If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplace (State or Foreign (Month, Day, Year) | 7 Under 26, 1920 | Virginia 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 X Months 245-12-4794 80 Yrs. Director Usual Residence of Decedent 10s. State 10b. County 10c. City. Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens. Importants if item 27 is marked other than "natural", or home 23s or 28s-f show with fully or other traumatic avant, the Medical Examinar must be notified at once. 1 ☐ Yes 2 No Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21221 U.S.A. 407 Edmunds Way Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 22No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yas, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 11. Merital Status Black, White, etc. 1 Never Married 2 Merried Specify: White 1 Yes 2 No Specify: 3€Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Housewife Own Home 18. Mother's Name (First, Middle, Maiden Sumama) 17. Fethar's Name (First, Middle, Last) Be Mary E. Garner 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Steta, Zip Code) 3222 Magnolia Ridge Road, Annapolis, Md. 21403 Donald Griffin (son) 20a. Mathod of Disposition 20c. Location - City or Town, State 1 ☐ Buriet 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Mem. Gardens 7/14/2000 Baltimore, Md. 21. Signtature of Fugeral Service Liqu 22. Nama and Addrass of Facility
Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 disease, or complications that caused the deeth. Do not entar the mode of dying, such as cardiac or raspiratory errest, at tailure. List only one cause on each line. Approximata Interval Batween Onset and Death Physician Immediate Cause (Final disease or condition resulting in death) · Arteriosclerotic Cardiovascular Disease Examine Due to (or es e consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): **PhysiciaryMedical** Due to (or as e consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 Yes 2 No à 24b. Wera autopsy findings aveilable prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 Yas 2 No 1 ☐ Yas 2 ☐ No Be 25. Was case referred to medical axaminar? 26. Plece of Death (Check only one) 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28d. Dascribe how injury occurred Certification: 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 1 Natural 5 Pending 1 Yes 2 No investigetion 21 Accident 6 Could not be 3 ☐ Suicide 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete)

P.O. Box 68760, 2 signed b Records, s cartificata has b Division of Vital director. this

Saltimore, Maryland 21215-0020

The law requires that the death certificate be executed physician s the burial or Attanding Physician: After this To the Hospital or Attanding within 24 hours after death.
To the Funeral Director: Afte completely filled in by the fun.

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4 Homicide

(Check only one)

29b. Signature and life of certifier

29a. Certifier

State Registrar

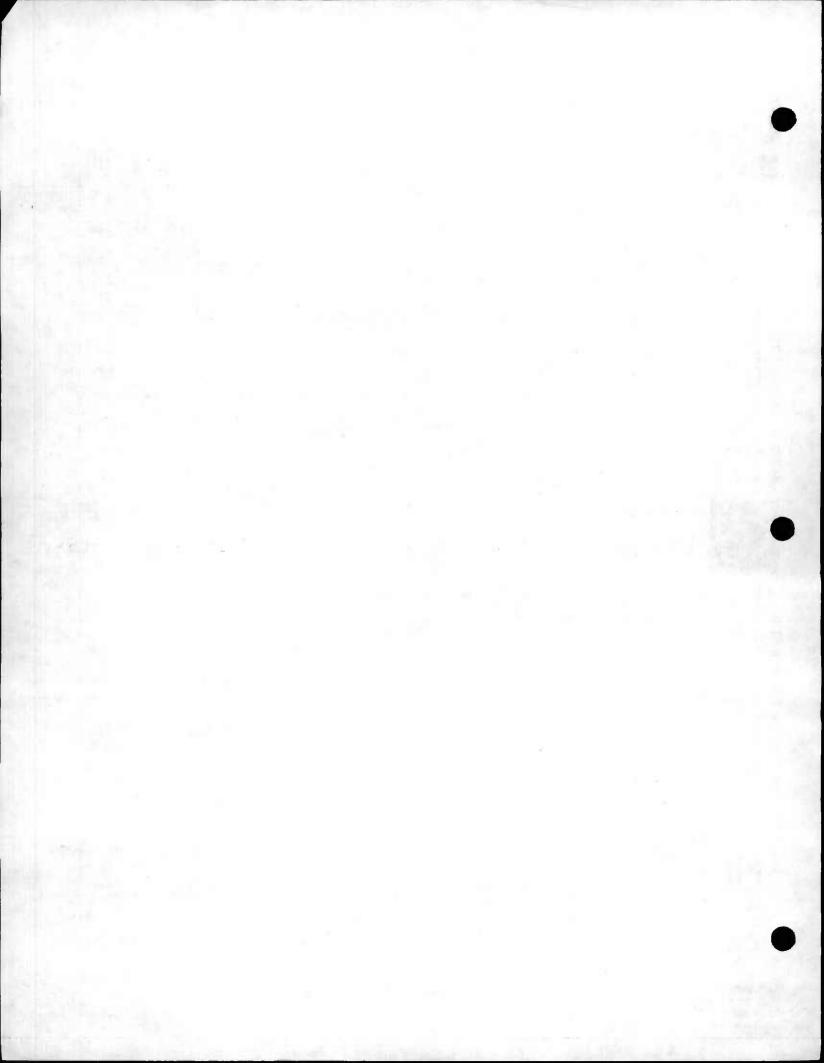
29c. Licanse number

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated.

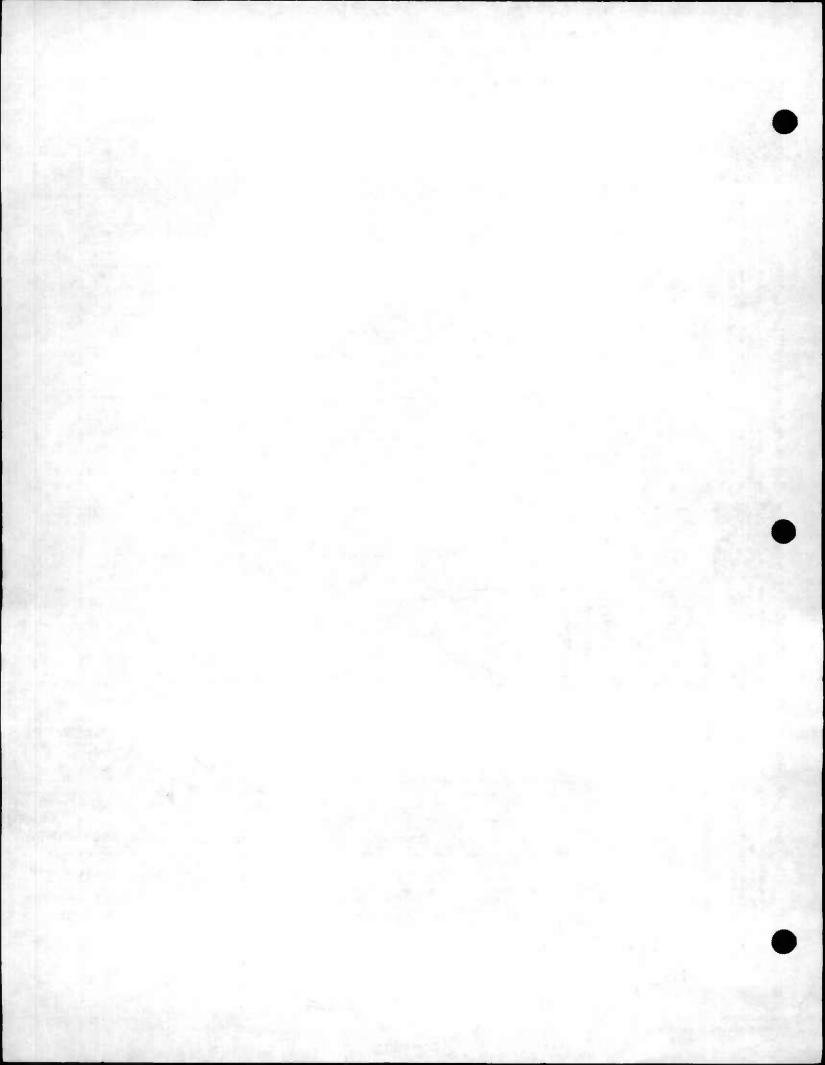
29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

225. Greene ST. Baltimore, Md 21201 MD MILITELLO 32. Registar's Signature 31. Date tiled (Month, Pay, Year)



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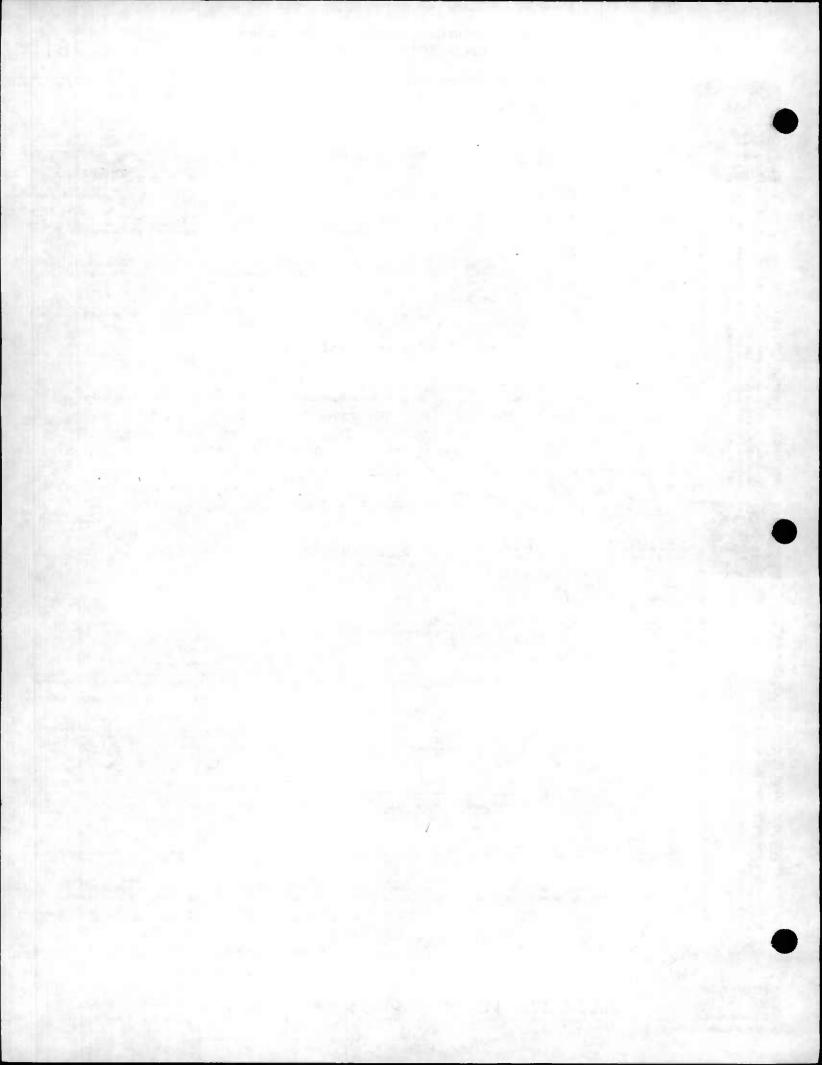


B.K.S JOHN JOSEPH GERAGHTY

Please Type or Print in Black Indelible ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 2236 |

			Certificate o	f Death		Reg. No.			
	1. Decedent's Neme (First, Middle, La	st)			2. Date of Dec		3. Tima of Death		
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To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page Medical Certification: To Be Com			etion end/or investigation, in m						
of the omple	29b. Signature and fittle of certifier		29c. Lica	anse number		29d. Date signed (/			
H = H 0	> Valueto	he Mail.	0.	C.M.E		JULY 8	, 2000		
LX	W Name and address of names of	completed cause of death (tra	m 23e) (Tuna Print)						
1),	Name and address of person who		ll Penn Street	, Baltimor	e, Mary	land 2120	1		
State	31. Data filed (Month, Day, Year)	32. Registrar's Sign							
Registrar		2000 Dener	~ B spo	uks					



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) **Physician** 2000 /Medical 4c. County of Death 4b. City, Town, or Location of De 4a Facility Neme (If not Institution, give street and number Examiner 10 Care 2 If Under 24 Hrs. 8. Date of Birth (Month, Dey, 5. Social Security Number 9. Birthpiace (Stete or Foreign Country) If Under 1 Yee 6. Sex Age (In yrs. lest birthday) **Funeral** Deys 220-07-824 Usual Residence of Decedent Months Hours 1□M 2♥F Director 9 ang with the Menyland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important: or flerms 23a or 28e-f ahov important: if item 27 is marked other than "natural; or flerms 23a or 28e-f ahov important: if item 23a or 28e-f ahov important: if item 23a or 28e-f ahov important: if item 23a or 28e-f ahov important: if item 23a or 28e-f ahov important: if item 23a or 28e-f ahov important: if item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ahov important: item 23a or 28e-f ah Mary 1 XYes 2 No Director MOI lang 10e. Street end Number Apt. 305 10f. Zip Code 10g, Citizen of What Country? Funeral Peges 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever In U.S. Armed Forces? 1 Yes 210 No 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Merital Stetus 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1□ Yes 2XNo Specify: þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 17. Father's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) Be 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Intormant's Name/Retationship (Type, Print) daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, Stete 20a. Method of Disposition Pete cemetery, crematory or other place) Buriel 2 Cremetion 3 Removel from Stete emoria 4 Donetion 5 Dother (Specify) 22. Name and Address of Facility

Joseph L. Ru 21. Signeture of Funeral Service Link uneral oseph Ave. North or complications that caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory errest List only one cause on each line. Approximete triterval Between Onset and Death **Physician** · Atheroselero Immediate Cause (Finel disease or condition resulting in deeth) /Medical 1090 Examiner Physician/Medical Examiner oronarg The law requires that the death certificate be executed attending physicien end for use es the bunal-trensit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initialed events resulting in death) Last Due to for a a consequence of) Division of Vital Records, P.O. Box 68760. Due to (or es e consequence of): USB 68 Pert II. Other algnificant conditions contributing to deeth but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 □ Probably 4 Unknown þ 8 cate has been sig pege 2 should b 24b. Were autopsy tindings aveilable prior to completion of cause of death? 24e. Wes en eutopsy performed? Completed 1 Yes 2 1 No 1 ☐ Yes 2 No After this certificate or Attending Physician: Be 25. Wes case referred to medical 26. Plece of Deeth (Check only one) Other: 450 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 2 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 DOA 28b. Time of Certification: 27. Menner of Deat 28e. Dete of Injury (Month, Day Year) 28c. Injury et Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation after death.

I Director: Aff 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 Suicide 6 Could not be 28e. Pleca of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C Hospital 100 Certifying Physician: To the best of my knowledge, death occurred at the time, date and pleca, end due to the cause(s) and manner es stated.

2 Medical Examiner: On the best of examinetion and/or investigation, in my opinion, death occurred at the time, dete and placa, and due to the cause(s) end manner stated. edical 29a. Certifier completely 29c. License number 29d. Dete signed (Month, Dev. Year) 29b. Signature end title of certifier 2000

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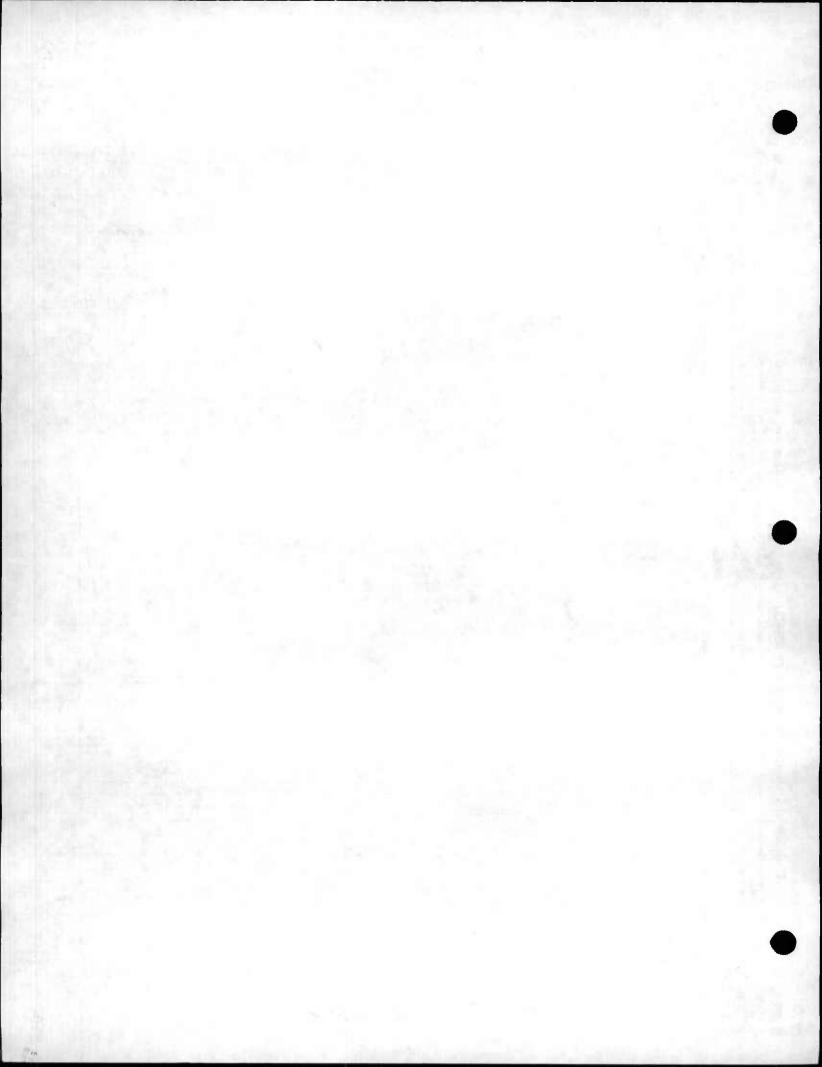
State Registrar 31. Date filed (Month, Day,

30. Name end address of person who completed cause of death (Item 23e) (Type, Print)

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32. Registrer's Signature

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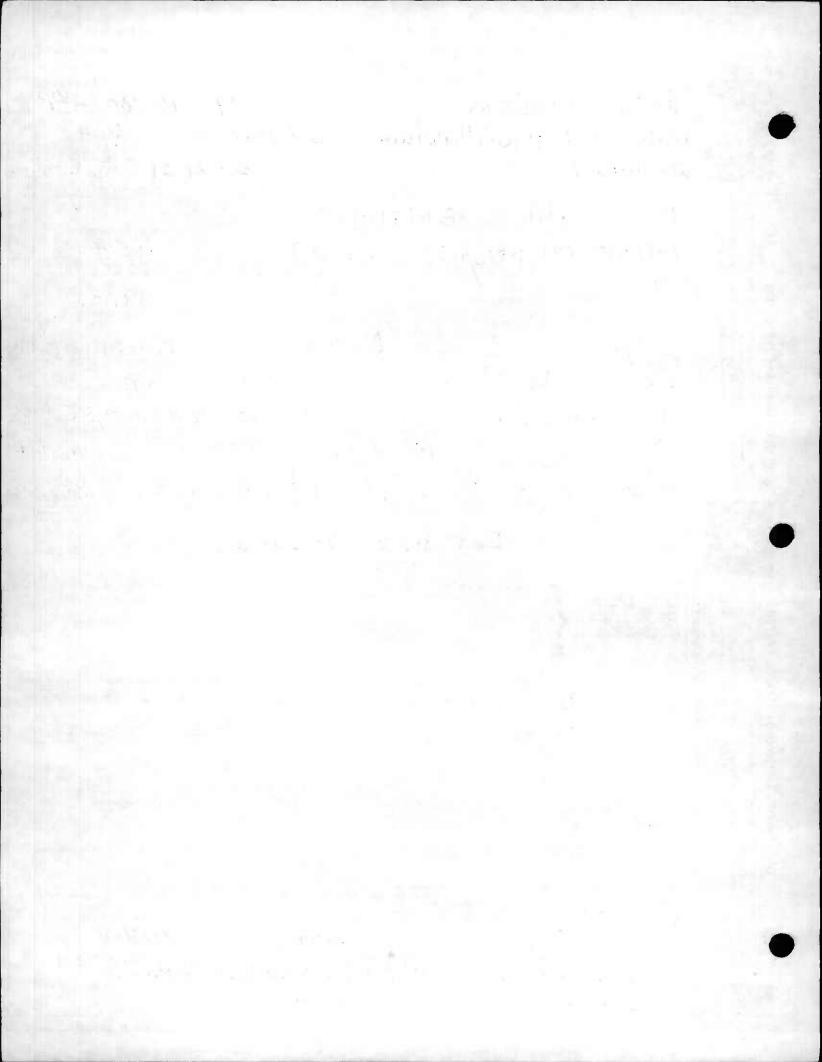


State Registrar

31. Date fited (Month.

MAHMOUD

32. Registrar's Signature



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Death Helen Helbig **Physician** July 11, 2000 07:30 /Medical 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Yeer | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Yeer) April 13, 1896 5. Social Security Number 6 Sax 7. Age (In yrs. last birthdey) Birthplece (State or Foreign Country) **Funeral** Months Deys Hours 065-09-8603 1 M 200 104 Yrs. Turkey Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "natural", or flams 23a or 28a-f show MD Anne Arundel Annapolis Yes 2 No Director Hygiens. other than "salura", or hams zon went, the Medical Examinar must be notif 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2700 S. Haven Road 21401 Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hyglene. Important: if them 27 is marked other than "natural", or its any injury or other traumetic event, the Medical Examina 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify White Specify: à XX Widowed 4 Divorced Year or Dates 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 0 Homemaker Own Home 18. Mother's Name (First, Middle, Maiden Sumeme) 17. Father's Name (First, Middle, Last) 88 Emest. Makraki Marta Grecorascou 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Mary Mongelli / Daughter 100 Spencer Road, Woodstock NY altimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State 7-15:00 Woodstock Cemetery Woodstock, NY 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Fecility Charles L. Stevens Funeral Home, Inc. Victor P. Doda, Jr. ture of Funeral Service Licensee 1501 East Fort Avenue, Baltimore Maryland 21230 23a. Pert1. Enter the disease, or complications that ceused to death. Do not enter the mode of dying, such as cerdiac or respiratory errest, shock, or heart feilure. List only one ceuse on each line. Approximate Intervel Between Onset and Death **Physician** /Medical Immediate Ceuse (Final 24 hours espiratory disease or condition resulting in death) Examiner Due to (or as e donsequence of The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or as a consequence of) signed by the atter Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown p 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy performed? completion of cause of death? has 1 Tes 1 ☐ Yes 2 ☐ No or Attending Physician: Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) To 1 Yes 2 2 ER/Outpatient 3 DOA this funeral 28d. Describe how Injury occurred 27. Menner of Death Certification: 28e. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? After t 5 Pending investigation 1 Natural 242 Accident 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 1 Coetifying Physician: To the best of my knowledge, death occurred at the time, date end place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifier 29c. License number Barbara 30. Name end eddress of person who completed ceuse of death (Item 23a) (Type, Print) napolis Ma2140, 900 Sestgatt 31. Dete filed (Month, Dey, Year) 82. Registrar's Sign State JUL 14 2000 Registrar

Prestomest.

Hensushah

Own Home

100 Spancer Road, Woodstock NY

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Mary Mongelli / Daughber

Woodstock Cemetery

Woodstock, NY

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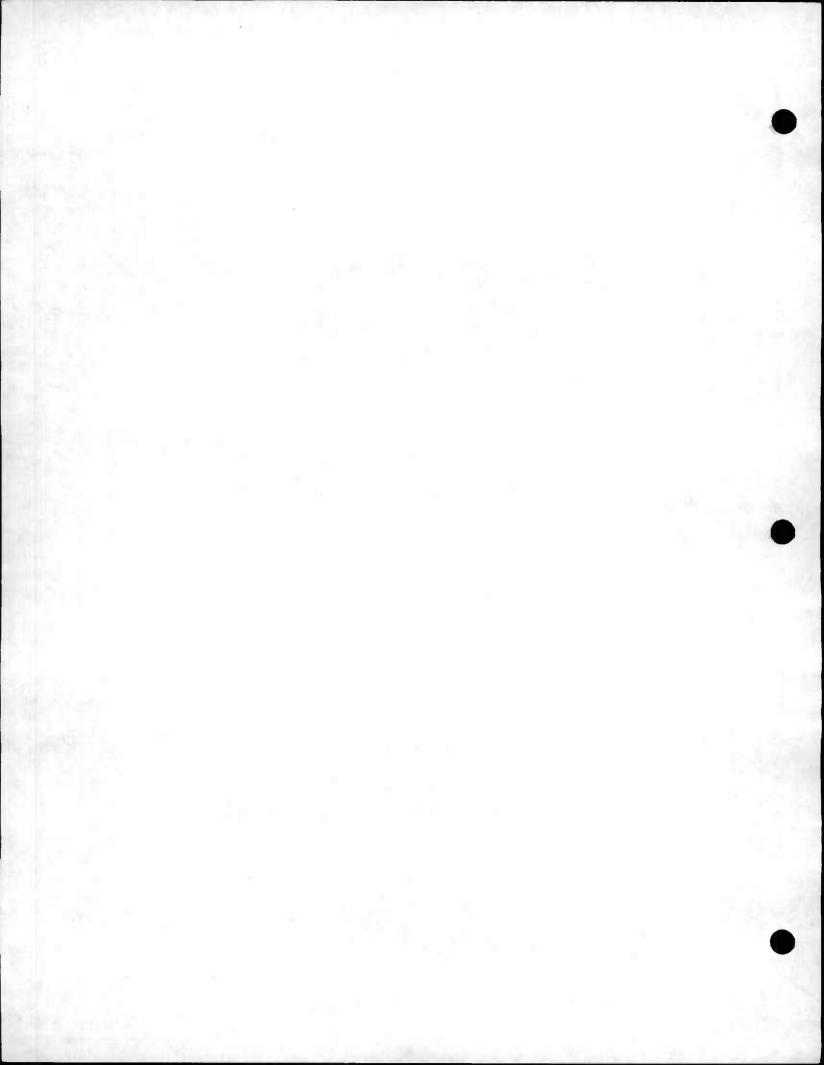
Charles L. Stevens Funeral Home, Inc. 1501 East Bort Avenue, Baltimore Maryland 21230

victor P. Ioda, Jr.

State of Mar	ryland / Department of Health	and Mental Hygiene

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Registrar DHMH 16 Rev 6/95



CS 00-3827-005 CRAIG HAUF

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22366

NDED ITEMS	23a,27,28a-f PER ME G7	85 7/18/00 AH	Certificate of	Death	Re	g. No.	2200
	1. Decedent's Neme (First, Middle, L.	nst)			2. Data of Death Month		3. Time of Dea
Physician /Medical	Craig Lo	uis Hauf			JULY		000 18:11
Examiner	4a Facility Name (If not Institution, gi FRANKLIN SOUARE I			4b. City, Town, or Lo ESSEX		4c. County of BALTI	
Funeral Director	5. Social Security Number 6. 220 – 72 – 1144	Sex 7. Age (In yrs. last 12 M 2 F 4 2	yrs. If Under 1 Yaar Months Days		8. Date of Birth		9. Birthplace (State or Fo Country) Marylan
ehow ohow	Usual Residence of Decedent 10a. State 10b. County	10c. City,	Town or Location		-		10d. Inside City Li
deeth with the Meryland ms 23s or 28s-f show trast be notified st herai Director	Maryland Balt	imore	Essex 10f. Zip Code		10	Og. Citizen of Wi	nat Country?
123a or	431 S. Taylor			21221		U.S.A	
raf, or he Exercise	11. Maritat Status Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 (X)No If Yes, Give Year or Dates:	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ※ No	dispanic Origin? (Sp an, Mexicen, Puerto Specify:	ecity Yas or No- Rican, etc.)		- Americen Indian, , White, etc. White
ygiene. ygiene. re then "natural", t, the Wadical Exe	15. Decedent'a E (Specify only highest gi Elementary/Secondary (0-12)	rade completed)	16a. Decedent's Usual Occup (Give kind of work done life. DO NOT use retire	duning most of work	ring	16b. Kind of Bus	iness/industry
r then r	10	Collega (1-4or 5+)	Steel W	Vorker	W. F.	Steel	Mill
tal Hys	17. Father's Name (First, Middle, Las	1)		18. Mother's Nam	e (First, Middle, N	faiden Sumame)
To Be Comp	Martin Hauf			Fred	a Haine	es	
Health end Men em 27 le marke other treumatic	19a. Informant's Name/Relationship Martin Hauf	(Type, Print) (father)	19b. Mailing Address (Street 431 S. Tay			-	
2 5 2 0	20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 4 □ Donetion 5 □ Other (Spec	Removal from State	ce of Disposition (Name of netery, crematory or other pla lens of Faith				City or Town, State
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hysician /Medical xaminer	tmmediate Ceuse (Finel disease or condition resulting in deeth)	NARCOTIC INTOXI		ng, such es cerulac	or respiratory and	,	Approximate tnterval Between Onset and Deat
<u> </u>		Due to (or a	as a consequence of):		1. 2.		
physician and is the burial-transit edical Examiner	Cause (Disease or injury that initiated events	С,	as a consequence of):				
0.0	resulting in death) Last	d					
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within To the comple	29b. Signature and title of certifier	as sil	29c. Licens		2		(Month, Day, Year)
	30. Name and address of person who	completed ceuse of death (Item 2		O.C.M.E.		JULY 1	.2, 2000
State	JACK M. 31. Date filed (Month, Day, Year)	7,7MS M.D. 32. Registrar's Signatu	111 Penn St		ltimore,	Marylar	nd 21201
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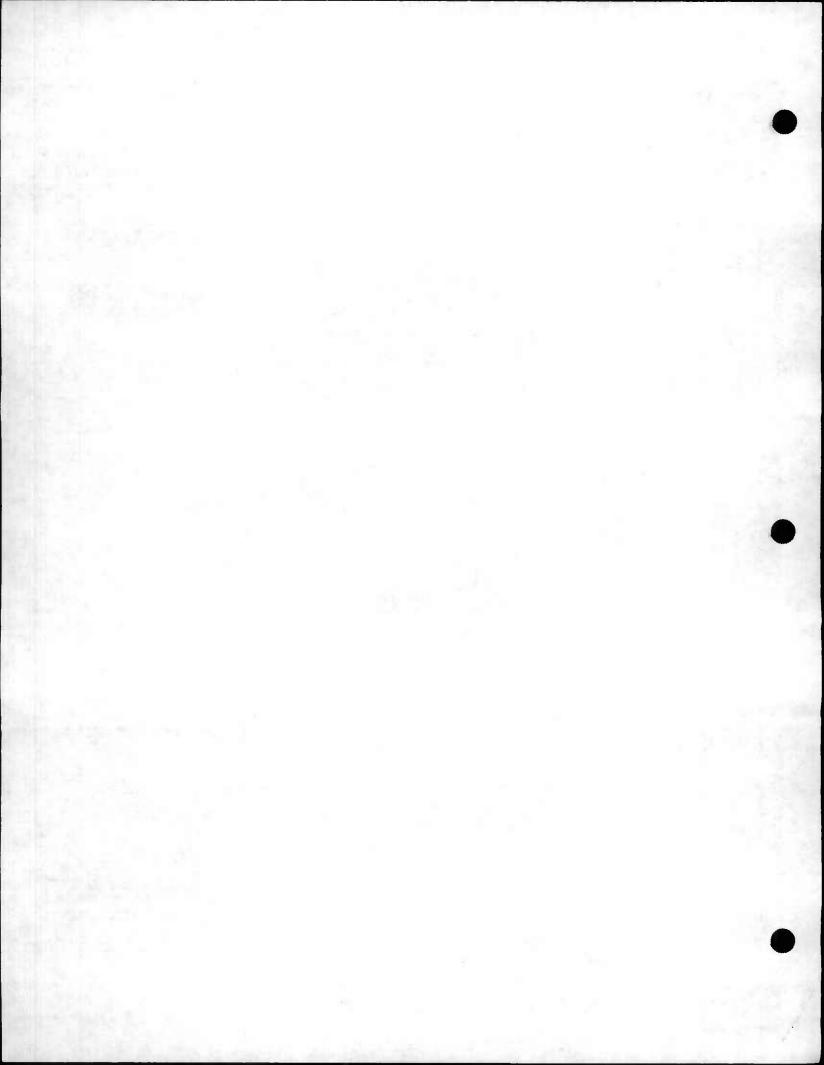
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Deeth 3. Time of Death **Physician** EDNA HOLLAND 11 10 2000 03:20 JULY /Medical 4c. County of Death 4a Facility Name (If not institution, give street end/number) 4b. City, Town, or Location of Deeth **Examiner** more 9. Birthplece (State or Foreign Country) Virginia 6. Sex 7. Age (In yrs. last birthdey) 5. Social Security Number 8. Date of Birth **Funeral** Deys 197 1□M 2QF 216 -28-Director irainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits other traumatic avant, the Medical Examiner must be notified at 1 Yes 2 □ No **Funeral Director** Maryland nore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? or items 23a 110 death Was Decedent of Hispenic Orlgin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever In U,S. Armed Forces? 14. Race - American Indien 11. Meritel Stetus permit. Pages 1 and 2 ahould be filed within 72 hours after a Department of Health and Mentel Hygiene. Important: If Ham 27 is merked other than "natural", or Hamany Injury or other traumatic avant. Important: If he in the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the investment of the inves Bleck, White, etc. 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Merried 2 Merried 1 □ Yes 2 No Specify Completed by 3 Widowed 4 □ Divorced HMERICAY 4110 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuel Occupation 16b. Kind of Business/Industry (Giva kind of work done during most of working life. DO NOT use retired) Elementary/Secondery (0-12) College (1-4or 5+) 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be ame 190, Informant's Nemer Reletionship (Type, Prigr) (daughter) 19b. Maiting Addrass (Street end Number or Rural Route Number, City or Town, 49 MSTrong 20b. Pleca of Disposition (Name of A cemetery, cremetory or other place) Deta 20e. Mathod of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremetion 3 □ Removel from Steta Mem. 4 Donation 5 ☐ Othar (Specify) 22. Name and Address of Facility

JOSEPH L. RU ge of Funerel Service/Licenses Joseph Hor uneral Ave. VId. 21216 North nter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, heart failure. List only one cause on aech lina. Approximete Intarval Batween Onsat and Deeth **Physician** /Medical immediate Cause (Final diseasa or condition resulting in deeth) SEPSIS. 4 days Examiner Due to (or es e consequence of): Physician/Medical Examiner 2 YEARS CVA The law requires that the death certificate be assecuted for use es the bunial-tran Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Ceuse (Disease or Injury Due to (or es e consequance of): Box 68760. ZYEMRS DEMENTIA that initieted events resulting in death) Lest Due to (or es e consequence of): P.O. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert t. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown of Vital Records. Be Completed by 24b. Wara autopsy findings evallable prior to completion of cause of daath? 24e. Wes en eutopsy performed? director, page 2 should this certificate has 1 Yes 2) No 1 Yes 2 No or Attanding Physician: 25. Wes case rafarred to medical 26. Placa of Deeth (Check only ona) Hospitel: 1 ☐ Inpatiant Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28c. injury at Work? 27. Manner of Deet 28a. Dete of Injury (Month, Dey Year) 28b. Time of 28d. Describe how injury occurred After Division 5 Pending 1 Netural after deeth.

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2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end menner stated. 29a. Cartifier To the Within 2 To the 29b. Signeture end titla of certifian 29c. License number 29d. Data signed (Month, Day, Year) m.D. D005473 11th 2000 JULY Monna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) FRENCEY M. DONNA DALE NURSING HOME 31. Dete filed (Month, Dey, 32. Registrar's Signature State Registrar

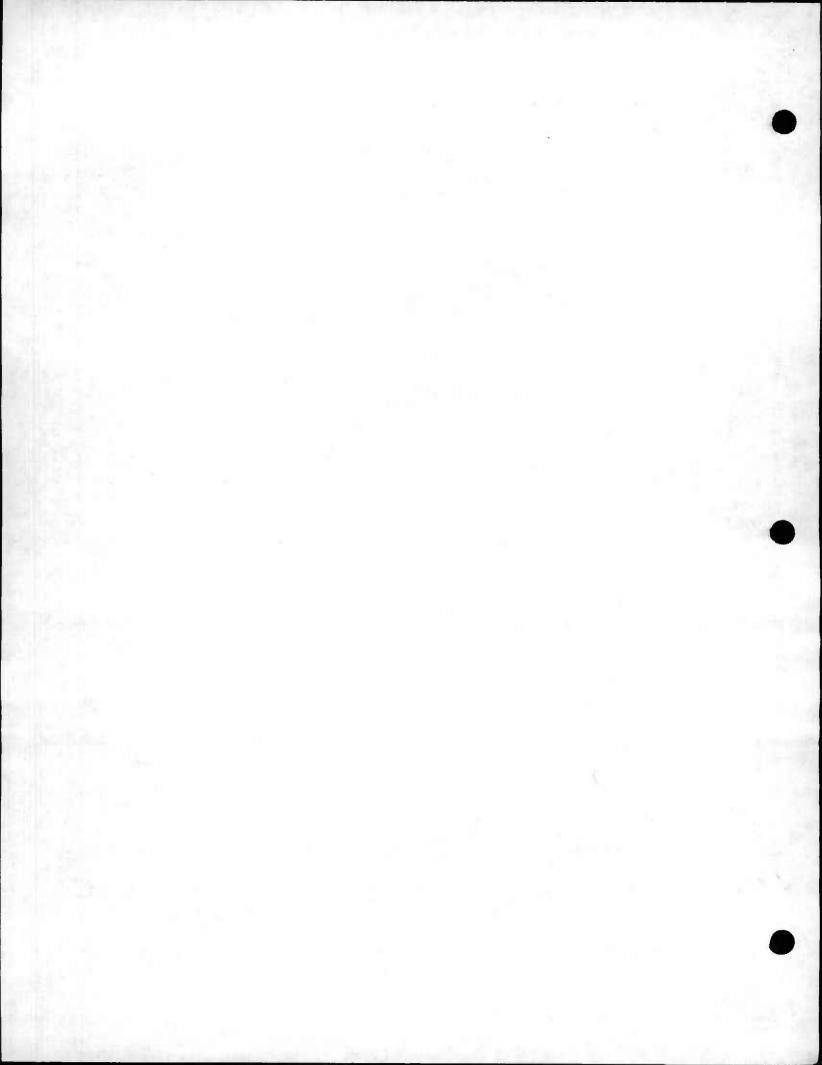
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Sequentiety list conditions, any, leading to immediate cause. Either Underlying cause given in Pert I. Due to (or es a consequence of): d. Due to (or es a consequence of): d. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause in the underlying cause given in Pert I. 24a. Was an eutopsy performed? 24a. Was an eutopsy performed? 24b. Were autovariable prompletion of death? 1 Yes 2 No 3 3 4 7 7 7 7 7 7 7 7 7		Immediate Ceuse (Finel disease or condition									tritervet Between Onset and Deeth
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Wernis L Churton OCME JULY 13, 2000	_	29b. Signeture and title of certifier	2 Chuto	4							
30 Neme and eddresa of person who completed ceuse of deeth (Item 23a) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201						eet, B	altim	ore, M	laryland	212	01
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] amend item 18 per fh G785 7/13/00 yg Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Deeth Month Day **Physician** MARGARET SAGE HILDRETH JOHNSTON July 11 9:45 AM /Medical 4a Fecility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPICE OF BALTIMORE: GILCHRIST CENTER Towson Baltimore County If Under 1 Ye If Under 24 Hrs. 8. Data of Birth (Month, Day, Year) Mar 8, 1911 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days Hours Months 1 M 2 KF 89 230-20-0203 Director Washington, DC Usual Rasidence of Decedent 10b. County 10c. City, Town or Location 10d. Insida City Limits r than "natural", or itema 23a or 28a-f shorte Medical Examiner must be notified at 1 ☐ Yas 2 No Maryland Baltimore County Towson Director 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 615 Chestnut Avenue 21204 Funeral 14. Race - Amarican Indian, Black, Whita, atc. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status 1 Nevar Married 2 Married 1 ☐ Yas 2 XNo Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: If Yes, Give Year or Datas: Specify: þ White 3 ☐Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working tifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) 5+ Elementary/Secondary (0-12) Psychologist Medical other permit. Peges 1 and 2 should be flie Department of Heelth and Mental Hy important; if item 27 is marked othe any Injury or other traumatic event pices. 17. Fether's Nama (First, Middle, Last) Mother's Nama (First, Middle, Maiden Sumama)
 Margaret Bradbury Rich Be William Hampton Sage, III Elizabeth Margaret Rich 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) (Son) Dr. Arthur M. Hildreth 912 Rolandvue Road, Towson, Maryland 21204 20b. Place of Disposition (Nama of cematery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 ☐ Removal from Stata 4 ☐ Donation 5 ☐ Othar (Specify) Green Mount Crematory 7/12/2000 Baltimore, Maryland 21. Signature Emprai Server Davison

Martin D. Layson 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road, Baltimore, Mary 1 and 21212
Apploximate Inter the mode of dying, such as cardiac or respiratory arrest,

Apploximate Intervel Between Onset and Deeth 23a. Part1. Enter the disease, or complications that caused the death. Do not enter shock, or haert teilure. List only one cause on each line. **Physician** Immedieta Causa (Final disease or condition rasulting in deeth) Aortic Anewysm /Medical Examiner Due to (or as e consequence of): Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events rasulting in death) Last Due to (or as a consequence of) requires that the deeth certificate be exacu Physician/Medical Dua to (or as a consequence of) Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed b by 24b. Ware autopsy findings available prior to completion of causa of death? 24a. Was en eutopsy performed? Completed 1 Yas 2 No 1 Yes 2 No 25. Wes casa referred to medical axaminar? Be 26. Place of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Nother (Specify) + 05pice Hospital: 2 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA o 27. Menner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Division 1 Netural
2 Accident 5 Pending invastigation I hours after death. uneral Director: Aft ely filled in by the fur 1 Yes 2 No 28f. Location (Street and Number or Rural Routa Number, City or Town, Steta) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify) To the Hospital or A within 24 hours after To the Funeral Directompletely filled in by 4 ☐ Homlcida Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and dua to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and tiffe of confider mo and addrass of person who completed cause of death them 23a) (Type, Print) N. Charles St. Balto, md ZIZOU N 6701 100 31. Date tiled (Month, Day, Year)

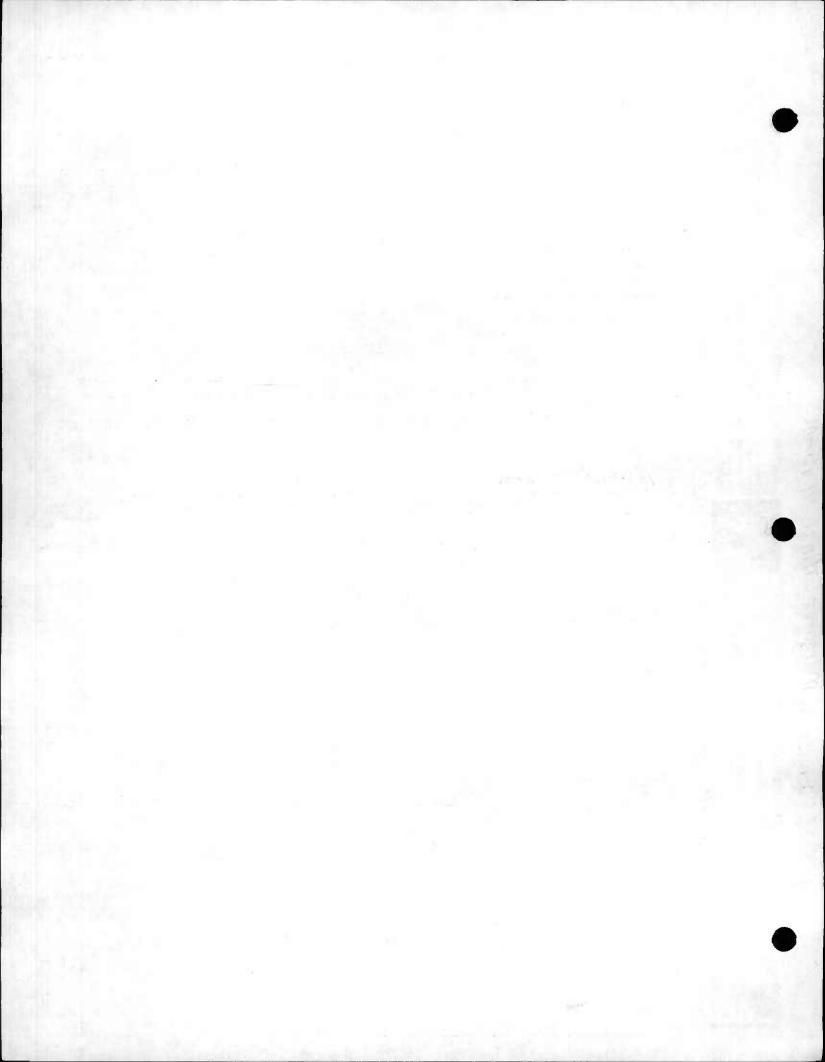
Registrar **DHMH 16 Rev 6/95**

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32. Registrar's Signatur



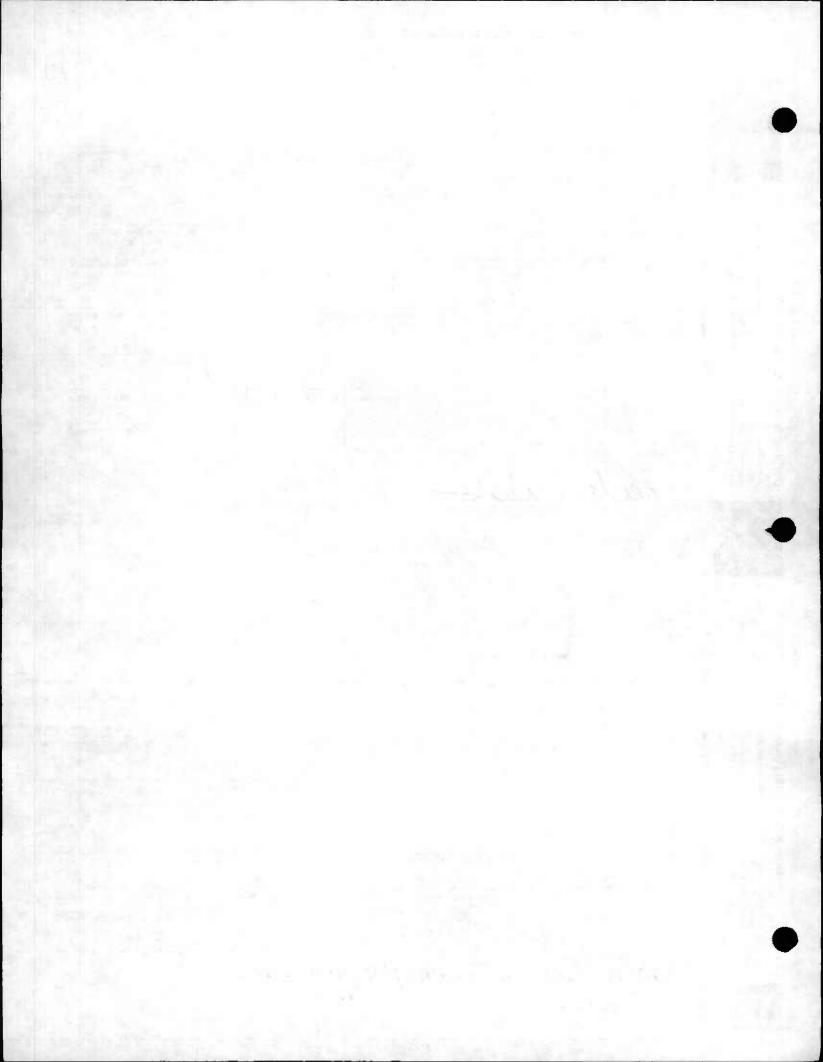
Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Data of Death 1. Decedent's Nema (First, Middla, Last) **Physician** JULY 11 2000 11:30 pm Edward W. Kempske /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER TOWSON BALTIMORE If Undar 1 Yaar | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Yaar) Birthplaca (State or Foreign Country) **Funeral** Hours Days 212-32-3687 12 M 2□ F 95 Yrs. Director 1905 | Maryland Jun 10, Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits Hygiana. other than "natural", or items 23s or 28s-f show the Medical Examiner must be notified at MD Baltimore 1 Yas 2 No Director Baldwin 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 4806 Carroll Manor Rd. 21013 USA Funeral 13. Was Decedant of Hispanic Origin? (Specify Yas or No-if Yas, specify Cuban, Maxican, Puarto Rican, atc.) Was Dacedant Evar in U.S. Armed Forces? 14. Race - Amarlcan Indian, Black, White, atc. 1 ☐ Yas 2 ☐ No If Yas, Giva 1 Navar Marriad 2 Memled 1 Yas 2 No Specify: à Specify 3 Widowed 4 Divorced Yaar or Datas White Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation (Giva kind of work done during most of working lifa. DO NOT usa retired) 16b. Kind of Businass/Industry Farmer Elementary/Secondary (0-12) Collega (1-4or 5+) Self employed 5 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be permit. Pages 1 and 2 should be Department of Health and Mental Important: if Item 27 is marked or Charles Kempske Frieda Jungfer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Mildred C. Kempske 4806 Carroll Manor Rd., Baldwin, MD 21013 altimoré, 20b. Placa of Disposition (Nama of camatary, crematory or other placa) Data 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Ramoval from Stata Jul 15 St. John's Lutheran Parkville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2000 21. Signature of Fatheral 22. Nama and Addrass of Facility Evans Funeral Chapel 8800 Harford Rd. Parkville, Part! Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onsat and Death **Physician** Immediata Cause (Final disaasa or condition rasulting in daath) /Medical Myo coude Examiner Examine The lew requires that the death certificate be executed the buriel-transit Sequentially list conditions, if any, leading to immadiata causa. Entar Undarlying Causa (Disaasa or injury that initiated avents resulting in daath) Last pue Dua to (or as a consequence of) Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical Dua to (or as a consequenca of): 80 use (Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wera autopsy findings evailable prior to completion of cause of death? Completed 24a. Was an autopsy performad? 1 🗆 Yas 2X No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Placa of Death (Check only one) Hospital: 15 Inpatiant 2 ER/Outpatient 3 DOA Other: 4 Nursing Homa 5 Rasidenca 6 Other (Specify) 1 Yes 2 No 2 After this 28c. tnjury at Work? 27. Manner of Death Certification: 28b. Tima of 28d. Dascribe how injury occurred 1 Natural 5 Panding death. 1 | Yes 2 | No Invastigation 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 3 Suicida 6 Could not be 28a. Placa of Injury - At homa, ferm, straat, fectory, offica building, etc. (Specify) 28f. Location (Straat and Numbar or Rural Routa Number, City or Town, Stata) 4 Homicide edicai 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the cause(s) and mannar as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end mannar stated. 29a, Certifier 29b. Signature end title of cartifian 29c. Licansa number 29d. Data signad (Month, Day, Year) 00 30. Name end addrass of person who complated causa of daath (Item 23a) (Type, Print VOUSON JX. 32. Registrar's Signatu 31. Data filed (Month, Day, Year) State

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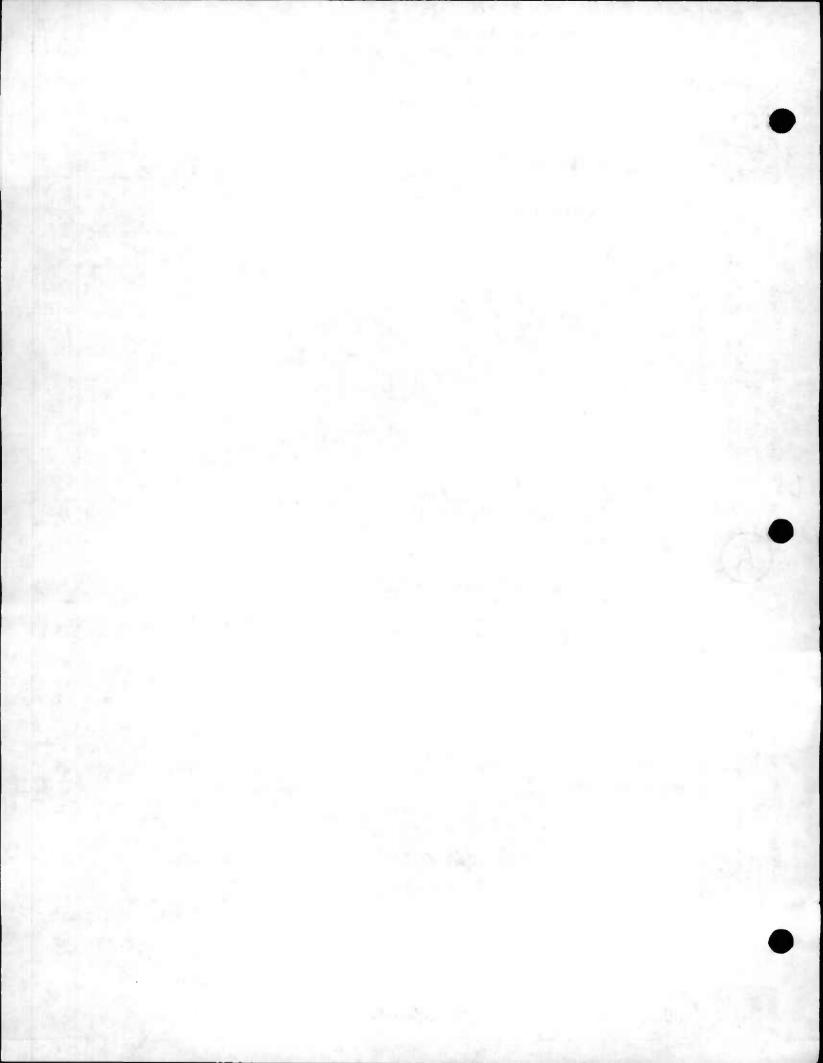


State of Maryland / Department of Health and Mental Hygiene

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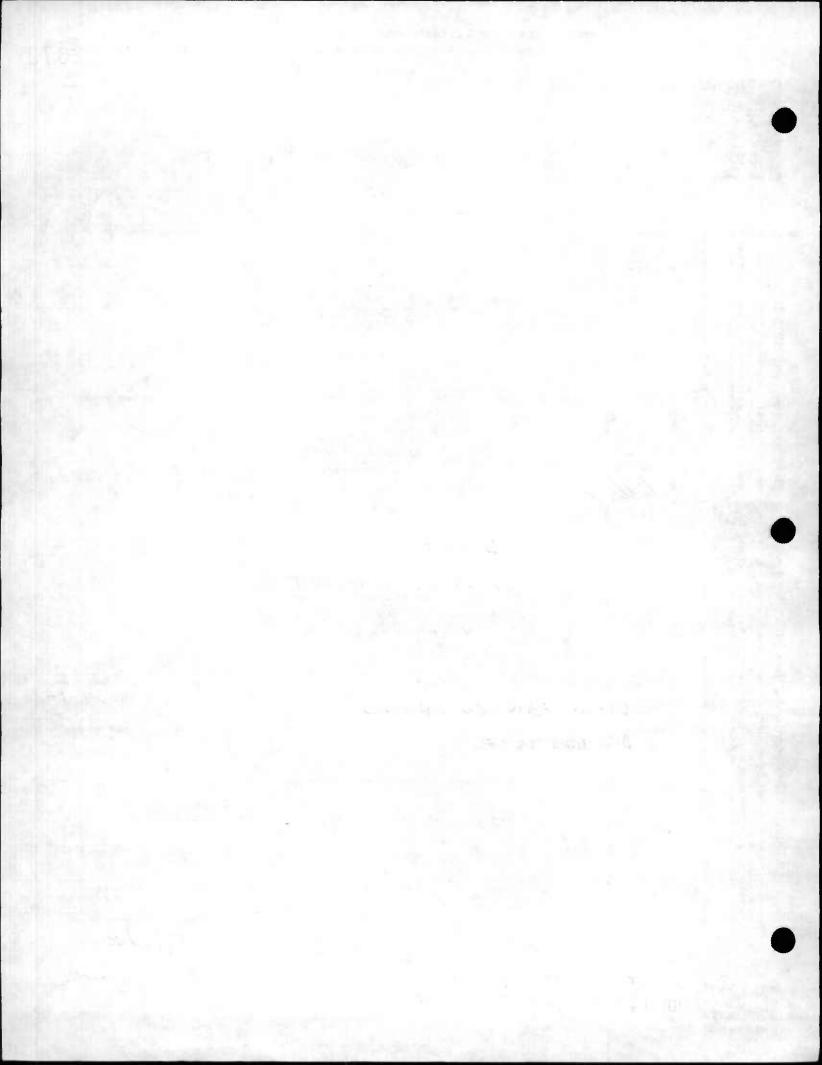
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State of Maryland / Department of Health and Mental Hygiene

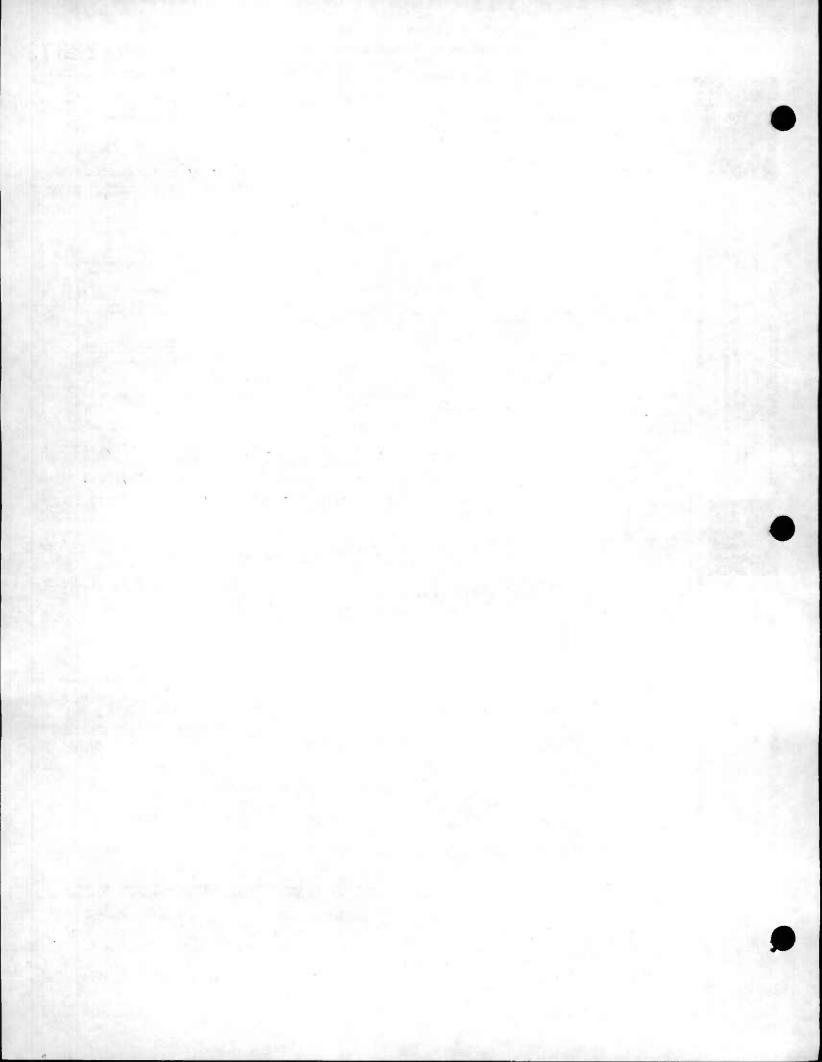
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State of Maryland / Department of Health and Mental Hygiene 11 22272

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death

22374

2. Date of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) **Physician** JULY 9 20ŎÖ 11PM KRIEGER DAVID /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner COLUMBIA **HOWARD** LORIEN NURSING & REHABILITATION CENTER 7. Age (In yrs. last birthday) | ff Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 8. Date of Birth Birthplace (State or Foreign MD untry) 5. Social Security Number Funeral 1**2** M 2 □ F 92 Yrs. 212-07-8165 Director Usual Residence of Decedent 10a State 10h Count 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or itama 23a or 28a-f ahow the Medical Examiner must be notified at Yes 2 No HOWARD Director MD CLARKSVILLE death with the 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5940 GENTLE CALL 21029 IISA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after nent of Health end Mental Hygiene.
Int: If Itam 27 is marked other than "natural", or Ne nry or other traumatic event, on Medical Exercise. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Baltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: WHITE Completed by 3€ Widowed 4 Divorced Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) PHARMACIST ASSISTANT PHARMACEUTICAL 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Be **HERMAN** KRIEGER YETTA RUBIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) SHELDON KRIEGER/SON 5940 GENTLE CALL CLARKSVILLE, MD21029 20b. Place of Disposition (Neme of 20a Method of Disposition Date 20c. Location - City or Town, State Department of I Important: If Its any injury or of polca. HAR SINAT CONGREGATION 1 Denial 2 Cremetion 3 Removal from State 7/13/00 BALTIMORE, MD. 4 Donation 5 Other (Specify) 22. Name and Address of Facility SOL LEVINSON & BROS. INC. 8900 REISTERSTOWN ROAD PIKESVILLE, MD 21208 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart tailure. List only one cause or each line. Approximete Interval Between Onset and Deeth **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) Examiner Examiner The lew requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Diseese or Injury that initiated events resulting in death) Last Due to (or es a consequence ot): physician s the burial Box 68760. Physician/Medical Due to (or es e consequence of): for use Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. Parkinsons Discare 1 ☐ Yee 2 ☐ No 3 ☐ Probably 4 Unknown Anem 19 þ 80 24b. Were autopsy tindings available prior to completion of cause ot deeth? Completed malnutuhon 24a. Was an autopsy performed? 1 Yes 200 No 1 ☐ Yes 2 1 No Physician: 25. Was cese reterred to medicel examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28e. Date of Injury (Month, Dey Year) 27. Menner of Deeth 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred After Division or Attanding 1 Neturel 2 Accident 5 Pending investigation death. 1 Yes 2 No the 24 hours after deat Funeral Director: 6 Could not be determined 3 ☐ Suicide 28t. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Place of tnjury - At home, term, street, factory, office building, etc. (Specify) filled in by 4 T Homicide Hospital 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) end manner as stated.

2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29a. Certifier To the Hosp within 24 hou To the Fune completaly fi (Check only one)

State Registrar

W

29b. Signature and title of guid

31. Date tiled (Month.

910/ Cherry

DHMH 16 Rev 6/95

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PRITAM 5 SA [no] M

32. Registrar's Signature

Snite

29c. License number

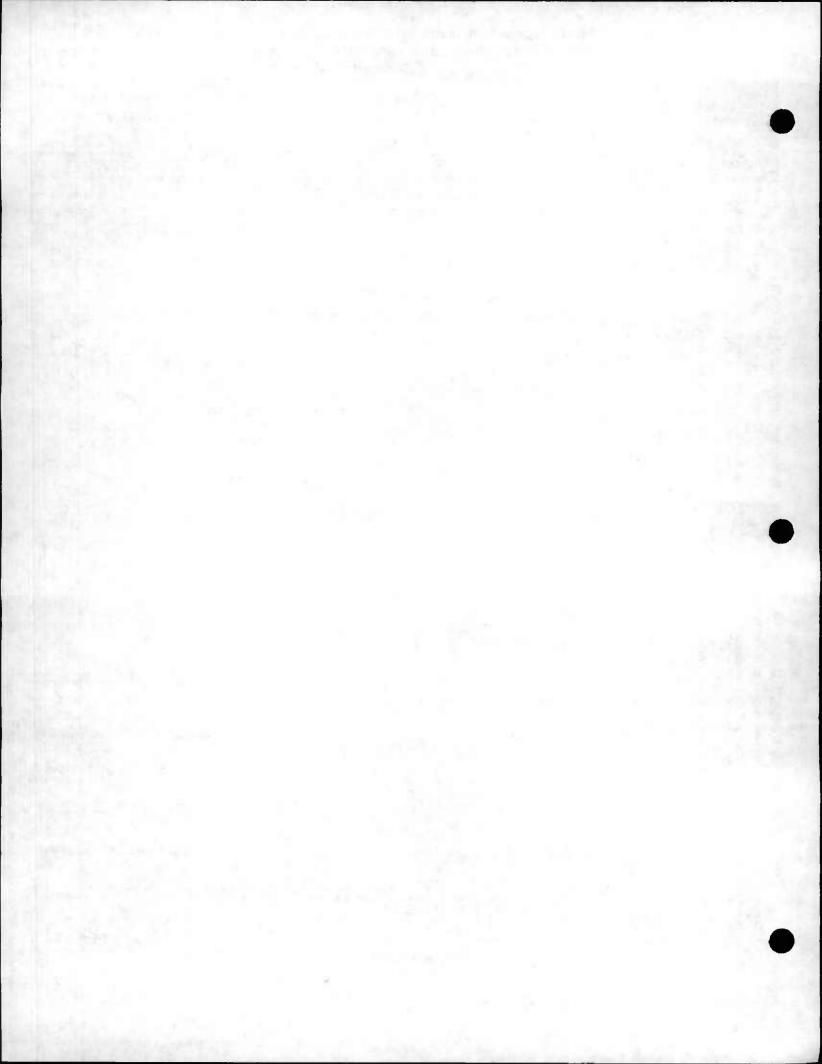
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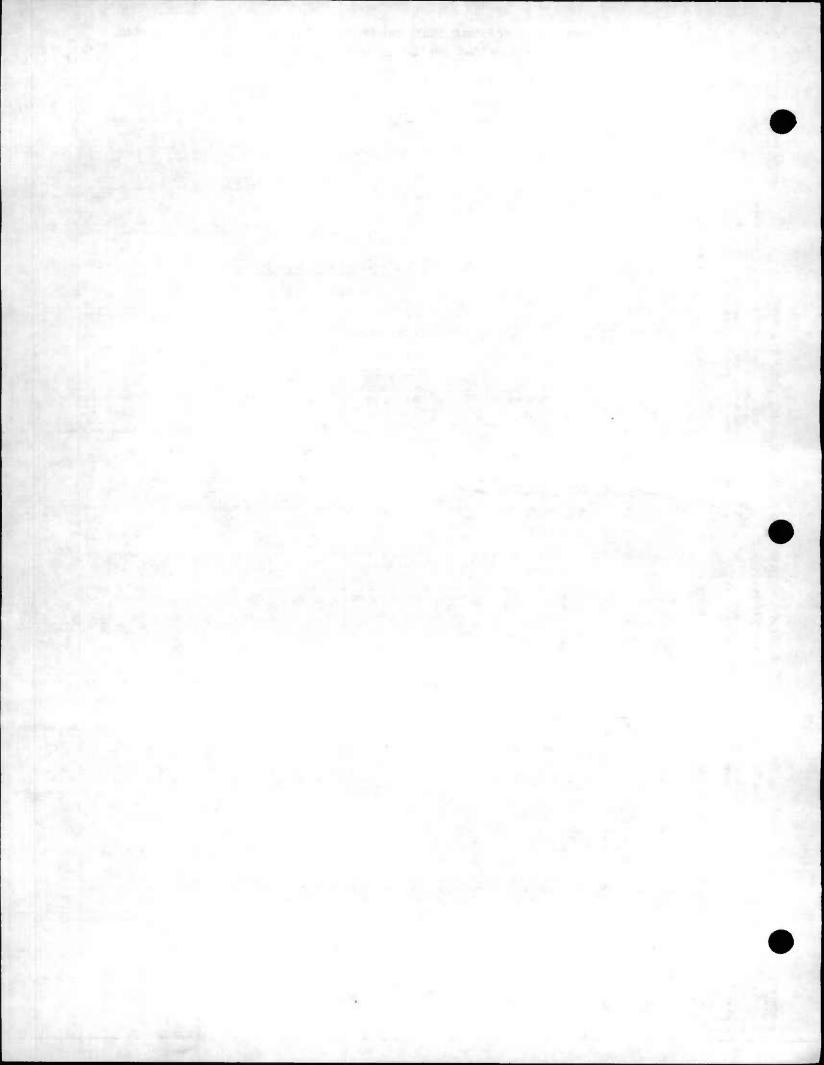
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29d. Date signed (Month, Dey, Year)

July 10, 2000



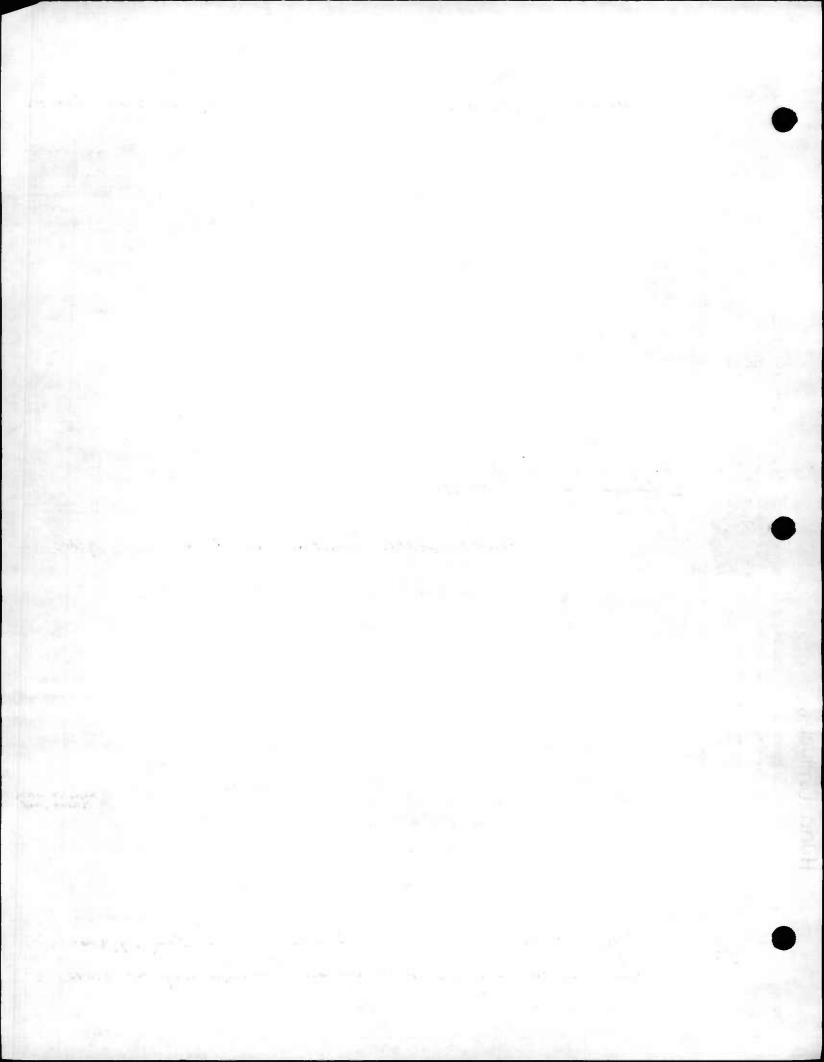
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re after death. at Director; After th led in by the funeral Certification:		Yes 2□No				
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d Dir	4 ☐ Homicide building, etc. (Specify)		City or Tow	m, Stete)		
	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time	ne, date end place	end due to the	cause(s) and men	ner es steted	
n 24 hound he Fund his pletchy fill	(Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my or and manner stated.	pinion, deeth occurr	red et the time,	date end place, ar	nd due to the ceuse(s	5)
Me office	29b. Signature and #ffe of certifier 29c. License	e number		29d. Date signed	(Month, Day, Year)	
3 F 8						
1	AD DS	1860		July 1	4,2000	
14 1	30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JONNYAN FULL MO 3460 GULLIST CTN DA 4 31. Date filed (Month, Day, Year) JUL 1 4 2000 Separa Signature					
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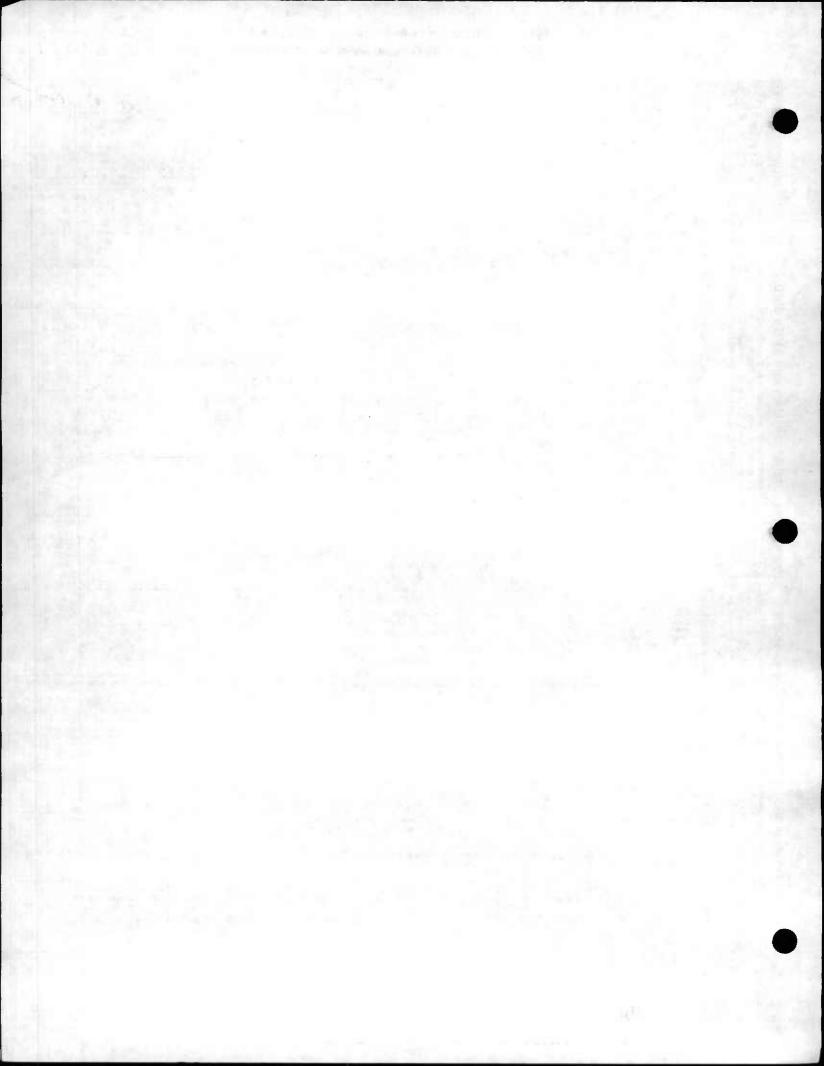


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ontributing to death but	not resulting in th	e underlying ceus	nevin ea	n in Part I.	23b. Did	tobacco use con	ntribute to the caus
					10	Yes 2□ No	3 Probably 4
					24a. Was	an autopsy ormed?	24b. Ware autops available prid
							completion of death?
					10	Yes 2 No	1 ☐ Yes 2
			2	26. Place of De	ath (Check only	one)	
Hospital: 1 Hipatien	t 2 ER/Outpa	atient 3 DOA	Other:	r: 4 Nursing I	foma 5 ☐ Resi	dence 6 Othe	er (Specify)
28a. Date of Injury (Month, Dey	Year) 28b. Tim	e of 28c	Injury a Work?	at ?	28d. Dascribe	how injury occurr	red
		М					
286. Place of Injur	ry - At home, farm, (Specify)	, street, fectory, o	ffice				er or Rural Route N
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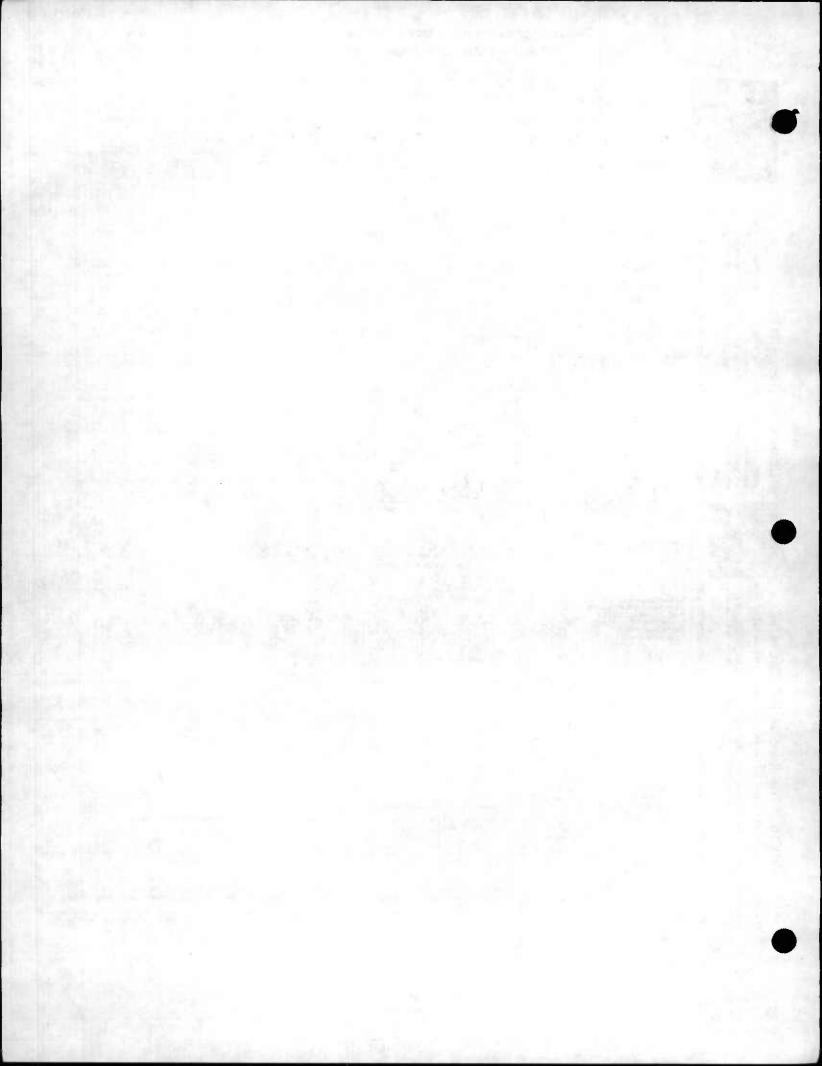
porks



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death Year **Physician** RICHARD EWIC 23:4 00 JULX 2000 /Medical 4b. City, Town, or Location of Deeth 4e Facility Name (If not institution, give street and number) 4c. County of Deeth Examiner The Johns HOOKINS salti more If Under 1 Yeer If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) Birthplece (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Deys 1₩ 2□ F 579-38-9938 Months Hours 68 Director Sept. 11,1931 Hawaii Usual Rasidence of Decedent deeth with the Maryland 10a Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits worle ms 23a or 28a-f short must be notified at 1 ☐ Yes 2 ☐No Director Anne Arundel Edgewater 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code terns 23a or 133 River Road 21037 IISA Funeral 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedant of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11 Merital Status permit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Important: if Itam 27 is marked other than "natural", or Itam any Injury or other traumatic event. 1 ⊠ Yes 2 □ No If Yas, Giva Yeer or Detes: 1 Never Merried 2 Merried 3altimore, Maryland 21215-0020 1 Yes 2 No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Union Printer Printing 17. Fether's Nema (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Richard P. Lewis, Sr. Pauline Dubrow 19e, Informant's Neme/Reletionship (Type, Print) 19b. Mailing Addrass (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Ida K. Lewis (Wife) 133 River Road, Edgewater, MD 21037 20b. Plece of Disposition (Nama of cemetary, cramatory or other pleca) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State Metro Crematory 4 ☐ Donetion 5 ☐ Other (Specify) Baltimore, MD 22. Name and Address of Facility 21. Signeture of Funeral Service Licensee Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 23a. Part1. Enter the disease, or complete caused the deeth. Do not enter the mode of dying, such es cardiec or respiretory arrest, shock, or haart failura. List only the ceuse on each line. Approximete Intarvel Batween Onsat end Death **Physician** /Medical Immediete Cause (Finel BRAIN INJURY DAYS diseese or condition resulting in deeth) Examiner 2 DAYS Examiner that the death certificate be executed physician and s the bunal-trans Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Diseese or injury that initiated events resulting in death) Last ESOPHAGEAL P.O. Box 68760. UNKNOWN Physician/Medical Due to (or es a consequence of) 88 Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert 1. 23b. Dtd tobacco use contributa to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown signed b þ Division of Vital Records. 24b. Were eutopsy findings eveilable prior to completion of cause of death? 24a. Was an autopsy performed? Completed has 1 ☐ Yes 2 ☐ No 1 Yes 2 No certificata 25. Wes case referred to medical examiner? Be 26. Placa of Daeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edicai Certification: To 2 ER/Outpatient 3 DOA 1 Inpatient this 27. Manner of Death 28e. Deta of Injury (Month, Dey Year) 28d. Describe how injury occurred To the Hospital or Attending PI within 24 hours after death.

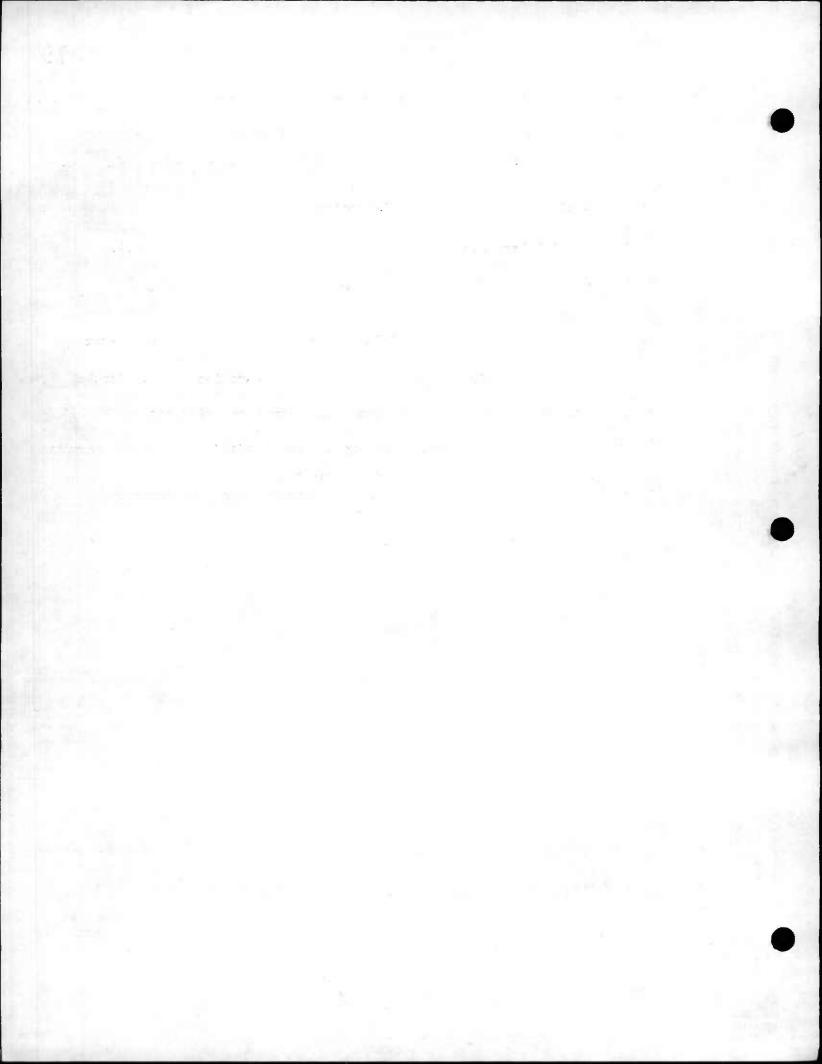
To the Funeral Director: After the completely filled in by the funera 28c. Injury et Work? After t 5 Panding Investigation 1/DNaturel 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be determined 3 Sulcide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specity) 4 ☐ HomicIda Cortifying Physician: To the best of my knowledga, death occurred at the tima, date end place, and due to tha causa(s) and mannar as stated.

| Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the tima, date and place, and due to tha causa(s) and menner steted. 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License numbar Md. Date signed (Month, Day, Year) 30. Neme and address of person who comple eted cause of deeth (ttem 23a) (Type, Print) SINGHAL JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE GT., BALTIMORE, MD 31. Data filad (Month, Day, Year) 32. Registrer's Signetur State Registrar



State of Maryland / Department of Health and Mental Hygiene 00 22379

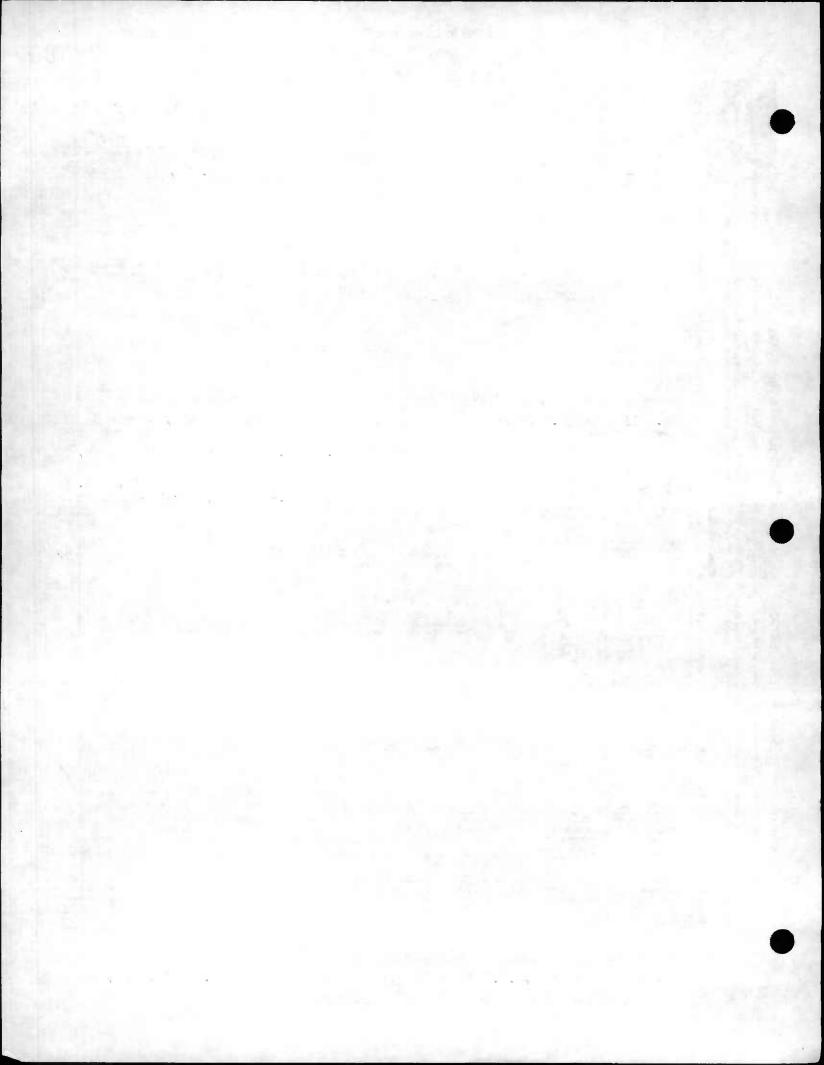
		Certificate of Death Reg. No.								
Di .	1. Decedent's Neme (First, Middle, La				2. Data of Death Month Dev Yeer 3. Time of Death					
Physicia /Medica	mittuted	Mildred Amelia		Lautenberger		July 1	3, 2000	Yeer	4 A.M.	
Examine	An English Manna (Manathatian ak	4a Facility Neme (If not institution, give street end number)				or Location of Death	4c. County	4c. County of Deeth		
* ''	1024 Green Hill Farm Road		Reist		erstown	stown Baltimore				
Funeral Director	5. Sociel Security Number 6. S 204 – 24 – 2327 Usuel Residence of Decedent	s. last birthday) Yrs. If Under 1 Year If Under 24 H Months Deys Hours Mi		n. (Month, Day, Year) Country)			(Stete or Foreign ylvania			
and 21215-0020 be filed within 72 hours efter death with the Maryland tiel hygiene. d other than 'natural', or Home 23s or 28s-f show event, the Medical Exeminar must be notified at Be Completed by Funeral Director	10a. Stete 10b. County	3033 3032			ity, Town or Location Reisterstown			10d. Inside City L 1 ☐ Yes 2		
	10e. Street and Number 1024 Green Hi	10e. Street and Number 1024 Green Hill Farm Road			10f. Zip Code 21136			10g. Citizan of Whet Country?		
		Armed Forces? 1 Yes 2X No								
	15. Decedent's E (Specify only highest gra	16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired)			vorkina	16b. Kind of Business/Industry				
	Elementery/Secondery (0-12) 12	College (1-4or 5+)		Sales Agent		ional g	Real	eal Estate		
)				18. Mother's Neme (First, Middle,		, Maiden Sumeme)		
arylan should be nd Mentel marked o	Henry F	. Koedding			Caroline		M. Strobel		el el	
		19e. Informent's Neme/Reletionship (Type, Print)			19b. Meiling Address (Street and Number or Rural Ros			oute Number, City or Town, State, Zip Code)		
CINL	John R. Lautenbe	rger Husband	1024	Green Hi	11 Farm	Road Reis	terstow	m, MD	21136	
2 5 2 2 5	20a. Mathod of Disposition 1 Burial 2 Cremetion 3	Removel from State	Pleca of Dispos camelery, crem	ition (Name of etory or other pla	ice)	Dete	20c. Location -	City or Town,	Stete	
Baltimo	21. Signature of Funerel Service Lice	4 Donation 5 Other (Specify) Carroll Cremation Serv. 7/14/00 Hampstead, Maryland 21. Signature of Funerel Service Licensee 22. Nama and Address of Fecility								
Balt permit. Department any inte	Kama B &	Pain	E]	line Fun	eral Hom			3.0	D 01106	
Physician /Medical	23a. Fart. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errast, Approximate Interval Between Onset and Deeth									
Examiner	rasulting in deeth)	Immediate Cause (Final disease or condition rasulting in deeth) Pelapsed lymphoma Jylar Due to (or es e consequenca of):								
cords, P.O. Box 68760, requires the the death certificate be executed seen signed by the attending physician and should be detached for use as the bunial-transit eted by Physician/Medical Examiner	Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Dua to (or es e consequence of): d.									
Box leath cert attendin	Dest II Other elegistics of conditions of	contributing to death but not resulting in the underlying cause given in Pert I.			22h Did tahana was sandhut ta the sand to the					
The law ata has be page 2 s	È	sulling in the underlying cause given in Pert I.				23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown				
	upleted by				24e. Wes e	on autopsy med?	evailab	outopsy findings ble prior to etion of cause h?		
						10 Y	1 Yes 2 No 1 Yes		s 2 No	
		26. Place of Deeth (Check only one)								
of Vita Physician: this certific ral director,	D ITTYES 20TONO	Hospitel: 1 ☐ Inpatient 2 [Home 5 Aesid	ome 5 Aesidence 6 Other (Specify)						
To the Respital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral Medical Certification:		28e. Dete of Injury (Month, Dey Year)	28b. Time of Injury	M 1	ry at rk?] Yes 2 ☐ No	28d. Describe how injury occurred		ed		
	3 Suicide 6 Could not be determined	28e. Pieca of Injury - At home, ferm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rurel Route Number, City or Town, Stete)			
	29e. Certifier (Check only one) 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, end due to the cause(s) end menner es stated. 2 Medicat Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date end place, end due to the cause(s) and menner stated.									
To the To the compl	29b. Signeture and title of certifier	29c. License number			2	29d. Dete signed (Month, Dey, Year)				
1 7 6	1 Sallar		DSS139			July 13, 2000				
12-1	30. Nama and address of person who Sally Avai John	completed causa of death (Ite	m 23a) (Type, P	rint)	altimor	e, Mary	land			
State	000 1 4 / ((()))	62. Registrer's Sign	neture	bouth						



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State of Maryland / Department of Health and Mental Hygiene 00 22380

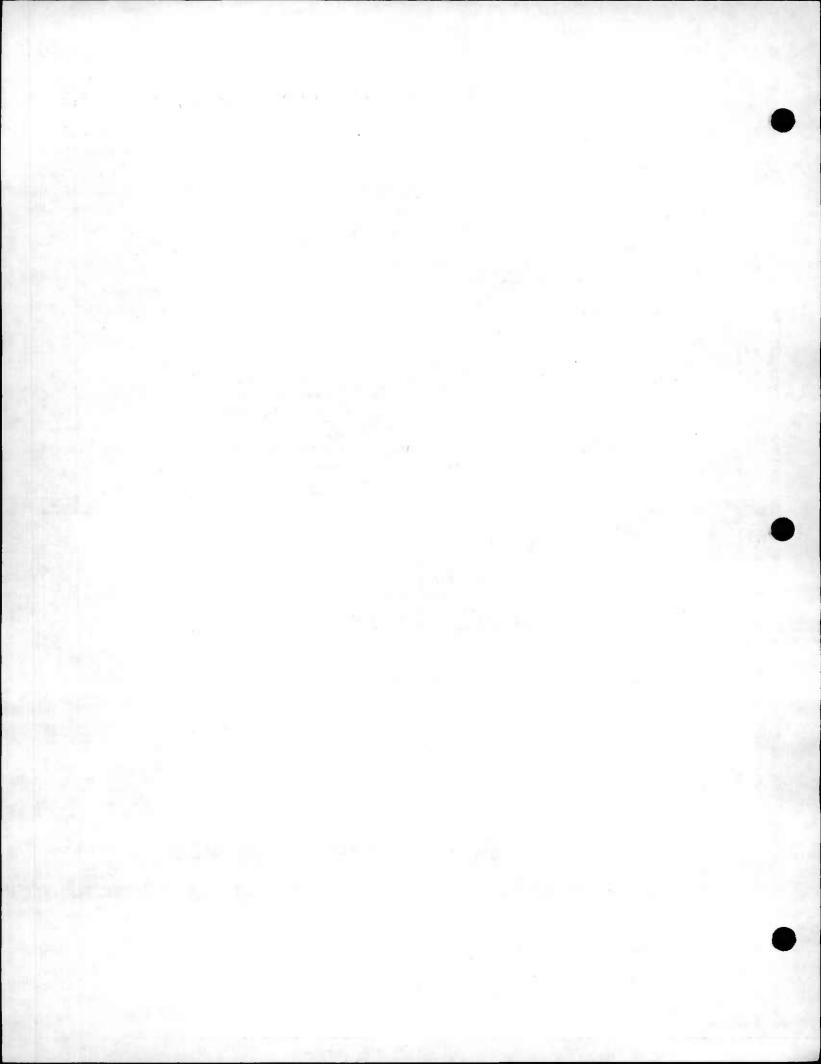
			Certificate of	Death	Re	g. No.	
Physician /Medical	1. Decedent's Name (First, Middle, Last) JAMES LO	ONG			2. Date of Death Month JULY	Day Year 8, 2000	3. Time of Death 12:40PM
Examiner	4a Facility Name (If not institution, give street e JOHNS HOPKINS BAYVH			BALTIM		4c. County of Deeth	/A
Funeral Director	5. Social Security Number 6. Sex 1 № M 2	7. Age (In yrs. last birtho	Months Davs	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Dey, Sept. 1	9. Birth Co. 9,1926 Pe	nplece (Stete or Foreign unity) ennsylvania
Maryland H ahow	Usual Residence of Decedent 10a. State 10b. County Maryland Baltimor	10c. City, Town o	r Location	D	undalk		10d. fnside City Limits 1 ☐ Yes 2XXNo
3s or 28s-f s	10e. Street and Number 15 Vista Mobile Dri	ve	10f. Zip Code	21222	10	g. Citizen of Whet Co	
72 hours effer death with the Maryland natural", or items 23s or 28s-1 show strat Examinet must be notified at sted by Funeral Director	1 Never Married 2 Married 1 5	s Decedent Ever in U,S. ned Forces? Yes 2 No es, Give or Dates: 1945-46	13. Was Decedent of H If Yes, specify Cube 1 ☐ Yes 223No	lispanic Origin? (Span, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)	14. Raca - Amer Black, White Specify:	rican Indian,
s .	15. Decedent's Education (Specify only highest grade comp Elementery/Secondary (0-12) Col 12 Years	leted) 16a. D. (C. (C. (ii. (ii. (ii. (ii. (iii.	ecedent's Usuel Occup Give kind of work done fe. DO NOT use retired Truck Dri	during most of work	ing 1	6b. Kind of Business/	ndustry
d 2 should be filed with and Mental Hydrology 7 la marked other than traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, traumatic event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, event, ev	17. Fether's Name (First, Middle, Last) John Ambrose Long		IIdek bij	18. Mother's Name			g mausery
ges 1 and 2 sh t of Health and If them 27 la m or other traum	19a. Informant's Name/Relationship (Type, Printed Ms. Elizabeth R. Mint 20a. Method of Disposition 1 ♀ Burial 2 □ Cremation 3 □ Remova	lick 1.	Hailing Address (Street 5 Vista Motisposition (Name of cremetory or other plea	oile Drive	Dundal	lk, Maryla Oc. Location - City or	nd 21222 Town, State
permit. Pages 1 ar Department of Hea Important: If Item; any Injury or other bhes.	4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee Proald R. Watson	A.		ss of Facility	Home of	Middle Riv	
certificate be executed ding physician and se as the burial-transit	Immediate Cause (Finel disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest	Due to (or as a conducto of the conducto) Due to (or as a conducto)	nsequence of):	monia			three days
C 3 E	Part ff. Other significant conditions contribution						to the cause of death?
aw requir	coronary arter	y disease,	, demen	tia	1 Ys 24a. Was an perform	autopsy 24b.	Were autopsy findings swailable prior to completion of cause of deeth?
	25. Was case referred to medical			26 Place of Deat	1 ☐ Ye		1□Yes No
B 4 5 0	examiner? 1 Yes 2 No Hospitel	Date of Injury (Month, Dey Year)	ne of 28c. Injury	er: 4 Nursing Ho		nce 6 Other (Spe	cify)
Cert and Cert	3 Suicide 6 Could not be determined 28e.		28f. Location (Str City or Town	reet and Number or Ru , Stete)	urel Route Number,		
he Hospit in 24 hour he Funer pletaly fill edical	(Check only 2 Medical Examiner: On	To the best of my knowledge, do the basis of examination and/od manner stated.	leath occurred et the time investigetion, in my control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the con	ne, date and pleca, pinion, death occur	and due to the ca red at the time, de	use(s) end menner as te end placa, and due	stated. to the ceuse(s)
Within Comp	29b. Signature and title of certifier	nadathmo		- 000	_	Od. Date signed (Mont	
State	30. Name and addids of person who complete Elizabeth Pynadath, M 31. Date filed (Month Day Year)		kins Bayvi		1 Ctr.	Baltimore,	MD 21224



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State of Maryland / Department of Health and Mental Hygiene 00 2238

			Certificate of	f Death	Reg.	No.	
Physician /Medical	1. Decedent's Neme (First, Middle, L.		ncis Laniewsl	ci, Jr.	2. Date of Death	Day Year	3. Time of Death 3:00 PM
Examiner	4e Facility Neme (If not institution, gi Genesis Heritage		rcare Ctr.	4b. City, Town, or Lo Dundal		4c. County of Death Baltin	more
Funeral Director		Sex 1 1 Age (In yrs. le 63	Yrs. If Under 1 Ye Months De		8. Data of Birth (Month Day Ye April 26	9. Birthy , 1937 Mar	place (State or Foreigntry) yland
incompleted by Funeral Director	10a. Stete 10b. County MD N/A		Town or Location			1	10d. Inside City Limit
r Hema 23a or 28a-fa for must be notified Funeral Director	10e. Street and Number 7200 Dunmanway		10f. Zip Code 21	222		Citizen of What Cour	ntry?
*natural; or frame 23e or 28e-f show added Examiner must be notified at letted by Funeral Director	11. Maritel Status 1 Never Merried 2 Married 3 Widowed 4 Microcod	12. Was Decedent Ever in U,S Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yaar or Datas:	13. Wes Decedent of If Yes, specify C	of Hispanic Origin? (Spi uban, Mexican, Puerto lo <i>Specify:</i>	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: Whi	atc.
ygiene. Nor then *neturn rt, tr = Modes Completed	15. Decedent's E (Specify only highest gr Elementery/Secondery (0-12)		16a. Decedent's Usuel Occ (Giva kind of work do: lifa. DO NOT use ret Truck Driv		ing 16b	Freight	dustry
B & dai	17. Father's Neme (First, Middle, Last Joseph S. Laniev			18. Mother's Name	(First, Middle, Maid M. Cyryca		
alth ar 27 le r trau	Mrs. Patricia How	vard-Sister	19b. Meiling Address (Stra 100 North Ma		· ·		Code)
× = 0	20e. Mathod of Disposition 19 Burial 2 Cramation 3 C 4 Donation 5 Other (Speci	Removet from State St.	ce of Disposition (Name of matery, cremetory or other p Stanislaus	Cemetery	7/13/00 Ba		
Department of Important: If any injury or once.	21. Signature of Funaral Service Lice	nsee Heather Cain		ford Road			1 21214
ding physicien and isse as the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Lest	a. METASTA Due to (or b. DIBBETE Due to (or c. HYPERT Due to (or d.	es a consequence of): SMELL as a consequence of): EMSIGN se a consequence of):	1145			
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s been signed a should be d					24a. Was an ar performed	i? av	era autopsy findings eilable prior to impletion of cause death?
certificate has b rector, page 2 s	25. Was case referred to medical			26. Placa of Death	1 Yes	20No 10	Yas 20 No
등 교	exeminer? 1 Yas 2 No 27. Menney of Death 1 Natural 5 Pending 2 Accident investigatio	28a. Dete of Injury (Month, Dey Year)	28b. Time of tnjury 28c. Ir		ma 5 ☐ Residence 28d. Describe how i	B 6 □Other (Specifinjury occurred	(y)
rs after death. al Director: After to all by the funer. Certification:	3 Suicide 6 Could not be determined		ne, ferm, street, fectory, office	28	28f. Location (Stree City or Town, St	t and Number or Run lefa)	al Routa Number,
Funer fely fill	29a. Certifiar (Check only one) To Certifying Pt	nysician: To the best of my know niner: On the basis of examinetic end mennar stated.	iedga, daath occurred at tha en end/or invastigation, in m	tima, data and place, a y opinion, deeth occurr	and due to the cause ed at the time, date	e(s) and mannar as s end plece, and due to	tated. the cause(s)
within To the comple	29b. Signature and title of certifiar	u Tollic	29c. Lice	nsa number	29d. 7	Data signed (Month,	Day, Year)
State Registrar	30. Name and address of person who was a second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the second with the secon	completed cause of deeth (Item 2	23e) (Type, Print) MG JCQ' ire Spann	blece &	Bet en	e MD 2	1222

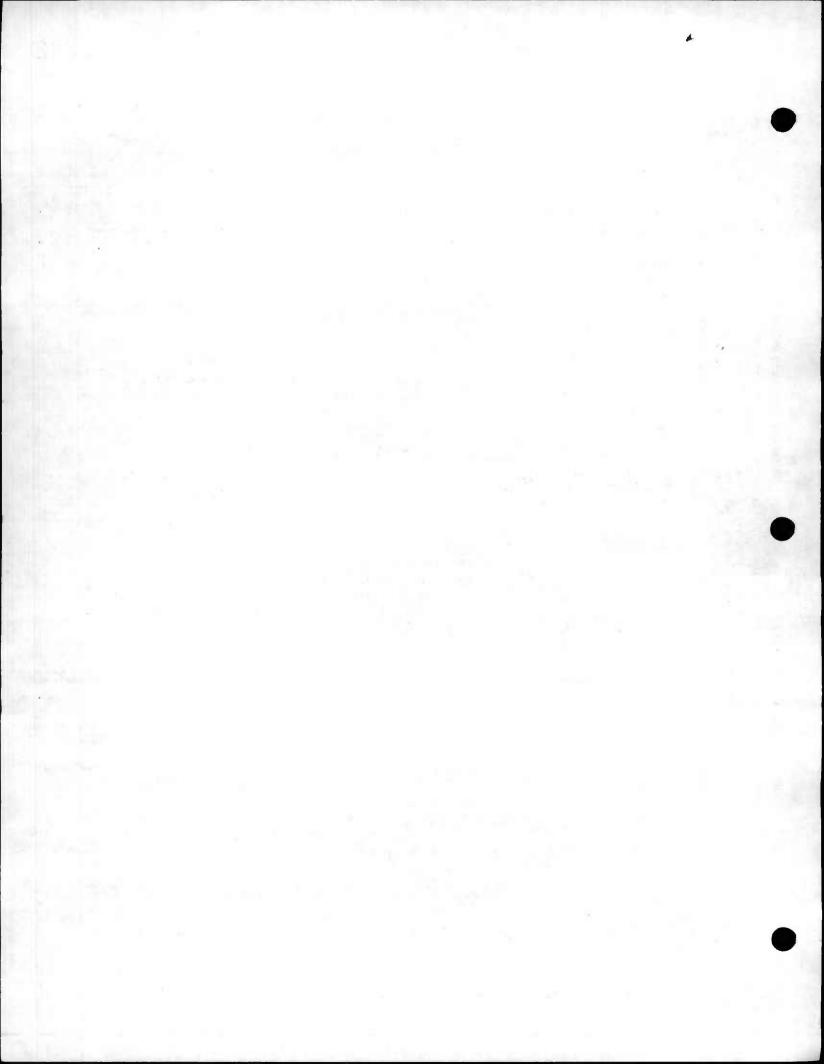


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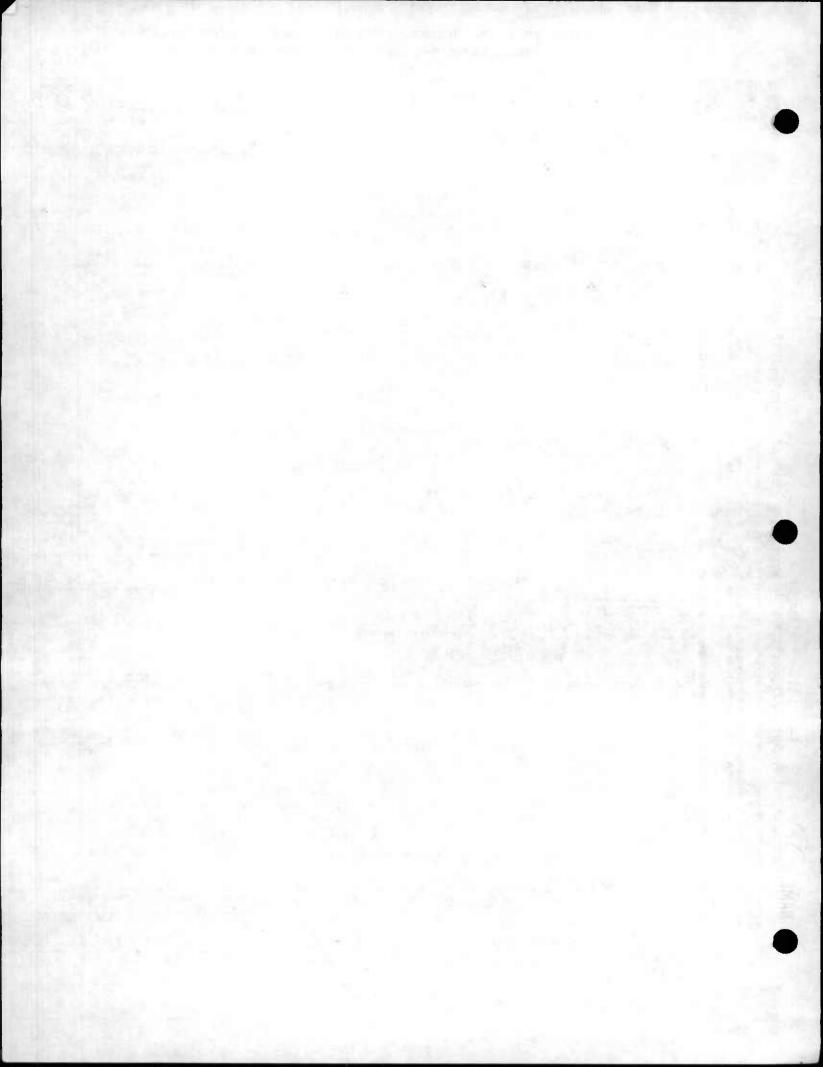
Certificate of Death

				Oortmouto	Or Doutin		Heg. No.	
	1. Decedent's Neme (First, Middle,	Last)				2. Date of D		3. Time of Death
Physician	Patricia Ward I	eonard				July	12 2	2000 12:30 PM
/Medical	4a Facility Name (If not institution,				4b. City. Toy	vn, or Location of Dea		
Examiner		,						
	685 Budleigh Ci				Timon		Balti	
neral		3. Sex 7. Age 1 M 2 X F	e (In yrs. last bin	Months	Year If Under 2 Days Hours	24 Hrs. 8. Date of B Min. (Month, D	irth lay, Year)	Birthplaca (State or Foreign Country)
ctor	212-50-1609	10 m 2M	53	Yrs.		Septemb	er 1 1946	Maryland
	Usual Residence of Decedent		10.05.7					T
	10a. State 10b. County		10c. City, Town	n or Location				10d. Inside City Limits
5	Maryland Baltim	ore	Timoni	um				1 ☐ Yes 2 No
ě	10e. Street and Number			10f. Zip C	ode		10g. Citizen of V	Vhal Country?
٥	685 Budleigh Ci	rcle		2109	13		United	Statos
Funeral Director	11. Marital Status	12. Was Decedent I	Ever in II S			in? (Specify Yes or N		e - American Indian.
S	1 Never Married 2 Marrie	Armed Forces?		Il Yes, specif	Cuben, Mexican,	Puerto Rican, etc.)		k, White, etc.
by F	3 Widowed 4 Divorced	If Yes, Give	NO	1 ☐ Yes 2	No Specify:		Specify	T71
2		Year or Dates:					10.0	White
Completed	15. Decedent's (Specify only highest	Education grade completed)	16a.	Decedent's Usual (Give kind of work	done during most	of working	16b. Kind of Bu	isiness/industry
du	Elementary/Secondary (0-12)	College (1-4or 5	i+)	life. DO NOT use	retired)			
Ö	12		F'	orist			Retail	Florist
Be	17. Father's Name (First, Middle, La	ist)			18. Mother	's Name (First, Middle	e, Maiden Sumam	Θ)
To	William Robert	Ward			Doro	thy Mary C	hester	
	19a. Informent's Name/Relationship	(Type, Print)	19b	Maiting Address (r or Rural Route Num		State. Zip Code)
	Daniel D. Leona	rd Ir (S				ourt Elkr		
	20a. Method of Disposition	14, 51. (5		Disposition (Name		Date		City or Town. State
	1 ⊠ Burial 2 □ Cremation 3	☐Removel from Stete	cemeter	y, crematory or oth	er place)		200. LOCATION -	City of Town, Stelle
	4 □ Donation 5 □ Other (Spe		Dulaney	Valley Mem	orial Garde	ens; 7/15/00	Timoniu	m, Maryland
	21. Signature of Funeral Service Lic	ensea			Address of Facility			
	Herren T.	Kettle		Mitchel	.I-Wiedet	eld Funera	al Home,	Inc.
_	23a. Part1. Enter the disease, or co	maliantiana that as and	the death Do			Baltimore		
	shock, or heart feiture. List or	ly one cause on each lin	ie.	ior enter the mode	or dying, such es t	cardiac or respiratory	errest,	Approximate Interval Between Onset and Death
an								Oriset and Death
al er	Immediate Cause (Finat disease or condition	Cardia	c Arres	t				
	resulting in death)	6.	Due to (or es a o	consequence of):				
P	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s			tension/H	wporlini	domin		
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8	Cause (Disease or Injury that initiated events	C						
ğ	resulting in death) Last		Due lo (or as a c	onsequence of):				
an/Medical		d						
by Physic	Part II. Other significant conditions	contributing to death bu	ut not resulting in	the underlying cau	se given in Part I.	23b. Dic	tobacco use con	stribute to the cause of death?
ş						128	Yes 2□ No	3 Probably 4 Unknown
7								
R							s an autopsy	24b. Were autopsy findings
ete						per	formed?	available prior to completion of cause of death?
Completed								
S						10	Yes 2 No	1 ☐ Yes 2 No
8	25. Was case referred to medical examiner?				26. Place	of Death (Check only	one)	
To	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatier	nt 2 ER/Out	tpatient 3 DOA	Other: 4 Nur	sing Home 5 🛱 Res	idence 6 DOthe	ar (Specify)
	27. Manner of Death	28a. Dale of Injur (Month, Day			Injury at Work?		how injury occurr	
5	1 Avaidant 5 Pending investigat		Year) Ir	njury M	Work? 1 ☐ Yes 2 ☐ N	io		
Certification:	3 Suicide 6 Could not	be one Diam of their	41.5				(Character of North	and Breat Breat Atlanta
E	4 ☐ Homicide determine	building, etc	iry - At home, fai :. <i>(Specify)</i>	rm, street, factory, o	ffice		(Street and Number own, State)	er or Rural Route Number,
o					Marie Control			
Ca	29a. Certifier 1 Certifying	Physician: To the best o	l my knowledge.	deeth occurred at	the time, date end	place, end due to the	cause(s) and ma	nner as stated.
edical	one) 2 Medical Ex	aminer: On the besis of and manner sta	examination and ted.	vor investigation, Ir	my opinion, deati	n occurred at the time	, date and placa, a	ind due to the cause(s)
ž	29b. Signatury and title of certifier	2 11		29c. I	icense number		29d. Date signed	i (Month, Day, Year)
	July 1	sollins.	MI	N	2557		July 13	. 2000
4	Arono 18	1			200 /		July 15	, 2000
	30. Name and address of person wh							
	Gwen Bolling, N	1.D. 7801 Y	York Roa			Towson, Ma	ryland :	21286
tate	31. Date filed (Month, Day, Year)	nn 32. Applistra	y's Bighature	& poor	Re			
aistrar	JUL 1 4 ZU	100	/					



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			C	ertifica	te of D	eath		Reg. No.	22303
Physician	Decedent's Name (First, Middle, Las John Richard Lans:						2. Date of De	Day	Year 2:00 L
/Medical // Examiner	4a Fecility Name (If not institution, give	street and number)	se		46. B	110	Location of Deel		
Funeral Director	5. Social Security Number 6. Se 216-40-0204		-	Month		f Under 24 Hrs Hours Min.	8. Date of Bir (Month, Da	th ly, Year) ary 4,41	Birthplece (State or Fore Country) Maryland
Maryland a-f show illed at	Usual Residence of Decedent 10a. State 10b. County Maryland Anne A		city, Town or en Bur						10d. Inside City Lin 1 ☐ Yes 2 🔀
ath with the Maryla 23e or 28e-f shot ust be notified at ral Director	10e. Street and Number 6508 Pampona Drive	е			Tip Code 1061			10g. Citizen of WI	nat Country?
Herra Herra Der m	11. Mental Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in I Armed Forces? 1 Yes 21 No If Yes, Give Year or Dates:	U,S. 13			anic Origin? (S Mexican, Puerl Specify:	pecify Yes or No o Rican, etc.)	7 4 5 521	- American Indien, , White, etc. White
of 2 should be litted within 72 hours at the and Mental Hygene. The marked other than "natural", or traumatic event, the Medical Exam. To Be Completed by F	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	/Gi	ve kind of v	sual Occupation of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of the court of	on ing most of wo	rking	16b. Kind of Bus	iness/Industry
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d other	17. Fether's Name (First, Middle, Last)				11			, Maiden Sumame)
Ment Ment Ment Ment Ment Ment Ment Ment	John Raymond Lans:	ınger				Ruth C	. Hillma	n	
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isa	30. Name and address of person who co STAGNES HE	ompleted cause of death (Ite	900 C	e, Print)	ANN	Bal	timore	e MD	21229
State	31. Date filed (Month, Dey, Year)	32. Registrar's Sign		1,000	lls				



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** 1830 PHYLLIS E. MACMILLAN 12 4c. County of Death JULY /Medical 4e Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner TOW SON MEDICAL CTR - E.R. BALTIMORE ST. JOSEPH Birthplace (State or Foreign Country) If Under 1 Year 8. Dete of Birth (Month, Dey, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. lest birthday) **Funeral** Deys 10 M 20 F Months Hours 89 217-01-4092 W. VIEGINIA Director APRIL 17, All Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Funeral Director BALTIMORE 288-7 MD LUTHERVILLE the Medical Examiner must be notif 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code or thems 23a or 21093 U. S. A. SEMINARY W AVE 300 Was Decedent of Hispenic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Raca - American Indien, Black, White, etc. 11 Marital Status hours after 1 ☐ Yes 2 ☑ If Yes, Give Year or Detes: 1 Never Married 2 Married 2 No Saltimore, Maryland 21215-0020 1 Yes 2 No Specify: þ Specify: 3 Widowed 4 □ Divorced WHITE Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiane. Elementery/Secondary (0-12) College (1-4or 5+) HOMEMAKER DOMESTIC permit. Pages 1 and 2 ahout be the Department of Health and Mental Hy Important: If Item 27 is methad other any Injury or other trauments. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be TRAYNOR PETER2 W. ELLA STEINER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. Informent's Neme/Relationship (Type, Print) MONKTON, MO. 2111 LANDING CATHERINE KLEIN , NIECE 1402 MAGEES 20b. Place of Disposition (Name of cametery, cremetory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Buriel 2 ☐ Cremetion 3 ☐ Removel from State JULY 14 4 ☐ Donetion 5 ☐ Other (Specify) BAUTMORE MD DIZULD RIDGE CAMETERY 7000 22. Name and Address of Facility EVANS FUNERAL CHAPEL 21. Signeture of Funeret Service Licensee ason 2325 YORK RD. TIMONIUM, MD. 21093 ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ort1. Enter the diseese nock, or heart failure. t **Physician** /Medical Immediate Cause (Final Bronchitis disease or condition resulting in death) Examiner Due to (or as a consequence of) Examiner Demention The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last bunel-tran Due to (or as a consequence of) physician Box 68760 Physiclan/Medical the Due to (or as a consequence of) 88 950 to P.O. Part II. Other stanificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ Records, 8 24b. Were autopsy findings available prior to completion of cause of death? 24e. Wes an autopsy performed? Completed has this certificate 1 Yes 2 No 1 Yes 2 No of Vital director. or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospitet: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 Ho 28a. Date of Injury (Month, Dey Year) funeral 27. Manner of Deeth 28b Time of 28c. Injury al Work? 28d. Describe how injury occurred After t Division 1 Netural 5 Pending investigation s after death. Il Director: Aff 1 Yes 2 No 2 Accident 6 Could not be 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 ☐ Suicide 28e. Ptaca of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide To the Hospital of within 24 hours of To the Funeral Dicompletely filled in 1 Cretifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the ceuse(s) and manner as stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and menner steted. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Dey, Year)

State Registrar

DHMH 16 Rev 6/95

JOSEPH

31. Date filed (Month; Day, Year)

Sald

2 44

BALDANZA

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

MD.

32. Registrar's Signature

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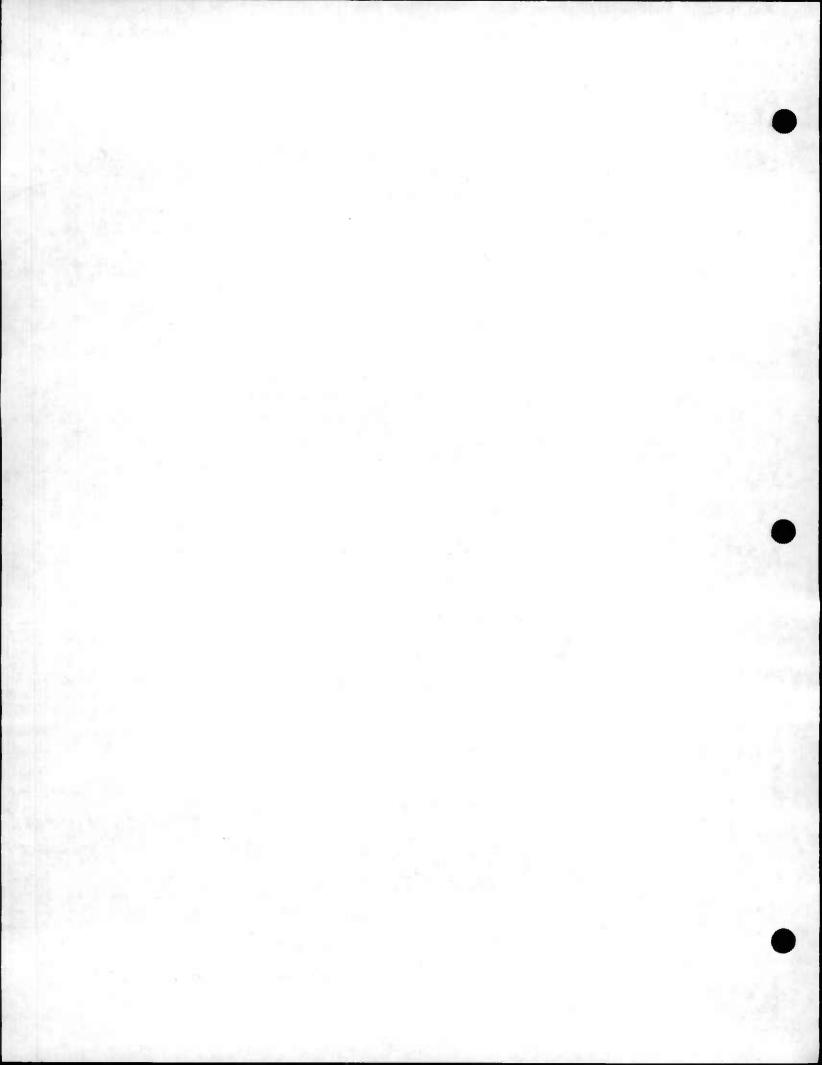
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4 Donation 5 Other 21. Signature of Funeral Serv	eral Servica Lica	ansee		22. 1	Name and Addr	ess of Facilit	y Inc	• Slack	Funera	al Hon	ne, PA		
		3871 Old Columbia Pike, Fllicott City, MD 21043 Intl. Enlar tha disease, or complications that caused the death. Do not enlar the mode of dying, such as cardiac or respiratory arrest, ock, or hearf failure. List only one cause on each line. Approximate interval Between											
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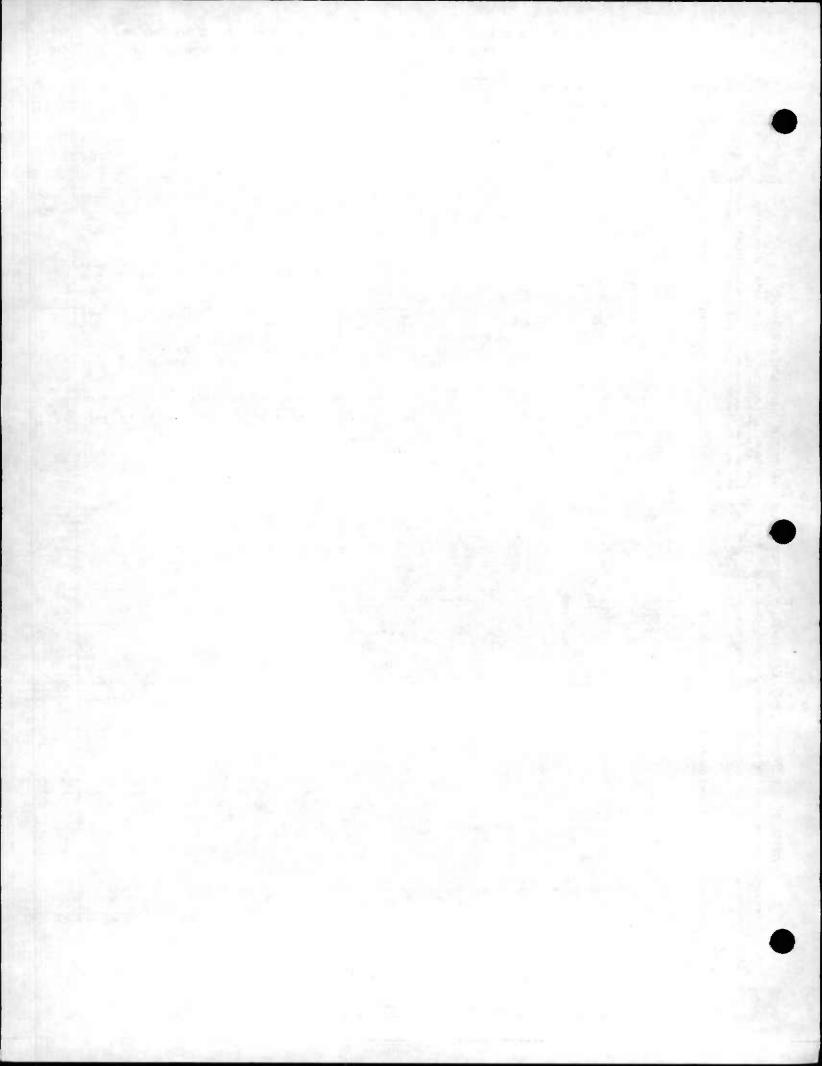
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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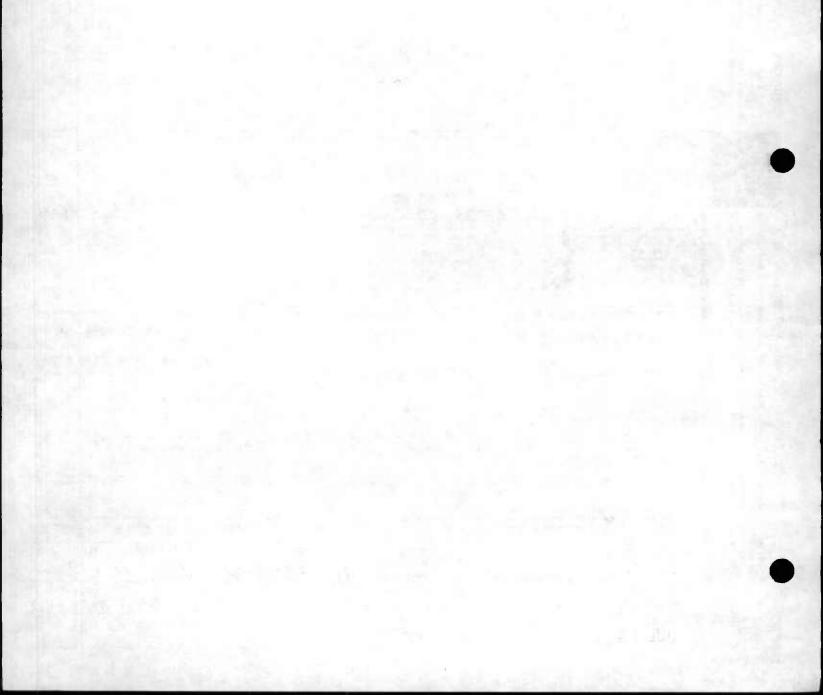
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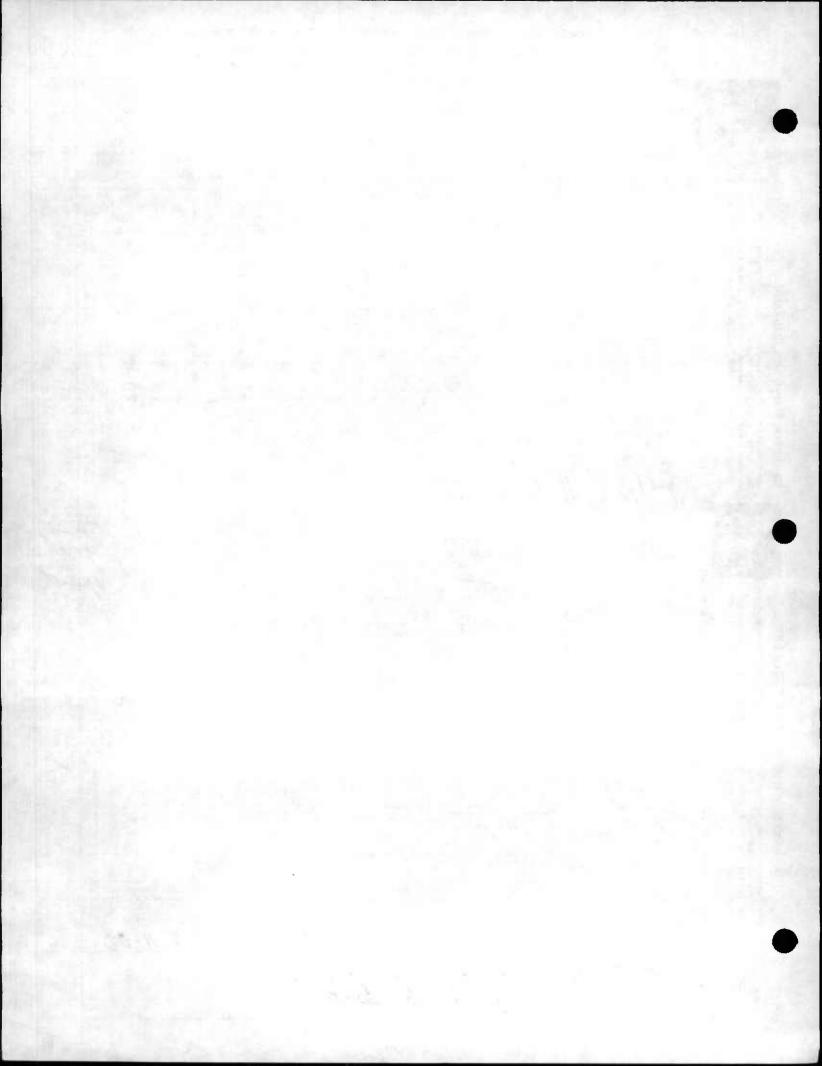
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				Certific	ate of	Death	F	leg. No.	tions.	
	Dhuniaian	1. Decedent's Name (First, Middle, Las					2. Date of Dea	Davi	Year	3. Time of Death
	Physician /Medical	William Joseph	McCracken				July 8,	2000	1041	6:02 PM
	Examiner	4a Facility Name (If not institution, give					Location of Death			
		8633 Black Oak Roa			and the second	Baltimore			timor	
	Funeral Director	210 11 1051	7. Age (In yrs. 78	Yrs.	ths Days	If Under 24 Hrs Hours Min		2, 1921	9. Birthple Countr Mary	cs (State or Foreign
	E .	Usual Residence of Decedent 10a. State 10b. County	10c. City	y, Town or Location					10	d. Inside City Limits
	the Mary 28a-f sh cotffied a ector	MD Baltimore	Ba	ltimore	Zin Coda			10- 04: 414	0-10-1-1	1 ☐ Yes 2 X No
	after death with the Maryla or herrs 23s or 25s-f shor miner must be notified at Funeral Director	8633 Black Oak Roa			21234			U.S.A.		
Maryland 21215-0020	D 5	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U, Amed Forces? 1 Å Yes 2 □ No WW I If Yes, Give Year or Dates:		ecedent of F specify Cub as 2 No	dispanic Origin? (S an, Mexican, Puer Specity:	Specify Yes or No- to Rican, etc.)	Specify:	- America k, White, et Whi	c.
2-0	72 ho	15. Decedent's Edu (Specify only highest grad		16a. Decedent's l	Usual Occup	pation during most of wo	rkina	16b. Kind of Bus	siness/Indu	stry
21	led within 72 ho ygiene. Ner than "naturi it, the Medical. Completed	Elementary/Secondary (0-12)	College (1-4or 5+)			during most of wo d)	9	Baltimo		s and
7	C Haria			Engine	er		4577 1 8 87 1 44	Electr		
ä	Be son	17. Father's Name (First, Middle, Last)					me (First, Middle,	Maigen Sumeme	9)	
2	d Men d Men marks marks	James E. McCracke		top Mailles Add	(Ct		Hagan	Chias Tour	Otata Zin (Parda l
	and 2 s selft an n 27 ls in her traus	Mrs. Paulina McCr	acken-spouse	8633 Bl	ack Oa		alimore,	Marylan	d 212	34
_	Pages 1 ment of H ant: If itse ury or off	20a. Method of Disposition 1 Buriel 2 Cremation 3 4 Donetion 5 Other (Specify,	Removal from State	lace of Disposition emetery, cremetory arkwood C	or other pla		7/12/00	Baltimon		
Ball	Departi Departi Importu eny inj ence.	21. Signature of Funeral Service Licens	Heather Ca:				eonard J. Baltimor			21214
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	Physician /Medical Examiner	Immediate Ceuse (Final disease or condition resulting in death)	a. ATHERO SCL Due to (o b. CEREBRO	EXOTIC ras a consequence	COLD of):	Dist	ALGERY 15E	DisEAS		2 YEARS
60,	certificate be executed rights by secured as the bunal-transit and and are the bunal-transit and a transit and a t	Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events	Due to (o	r es e consequence	of):					
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ă	d for	Part II. Other significant conditions co	ntributing to death but not resu	ulting in the underlyi	no cause on	en in Pert I	23h Did t	ohacco usa con	tribute to	the cause of death?
. P.C	ires that the death cert signed by the attending do be detached for use do by Physician/N	DIABETES /	relytus							bly 4 Unknown
Division of Vital Records,	been shoul	CHRONIC K	ENAL F	FAILUM	KE		24e. Was a perfor	an eutopsy med?	avai	e autopsy findings lable prior to pletion of cause eath?
ř	The law ite has bage 2						1 🗆 Y	es 208No	10	Yes 2□No
Ia	certificate irector, pag	25. Was case referred to medical				26. Place of De	ath (Check only o			
>	hysici his cer il direc	examiner? 1 ☐ Yes 2 KNo	Hospitel: 1 Inpatient 2	ER/Outpatient 3	DOA OII		Home 5A Resid		er (Specify)	
0 00	Attending Physician: In death. Sector: After this certification: To Be (27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Dey Year)	28b. Time of Injury	28c. Inju Wo			ow injury occurr		
DIVISI	विश्वेद म	3 Suicide 6 Could not be determined	28e. Ptace of Injury - At ho building, etc. (Specif)	ome, farm, street, fa	ctory, offica		28f. Location (S City or Tow	Street and Numbern, State)	er or Aural	Route Number,
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	110	Ilias 15	Thanlow	NS	D	0035	406	July,	11	, 2000
	10	30. Name and address of person who o	ompleted cause of death (Item	-000 S.	AMA	RITA	n Hos	P. BA	LTIY	ore, MD
	State	31. Dete filed (Month, Day, Year)	32. Registrer's Signa	ture Apork	20					



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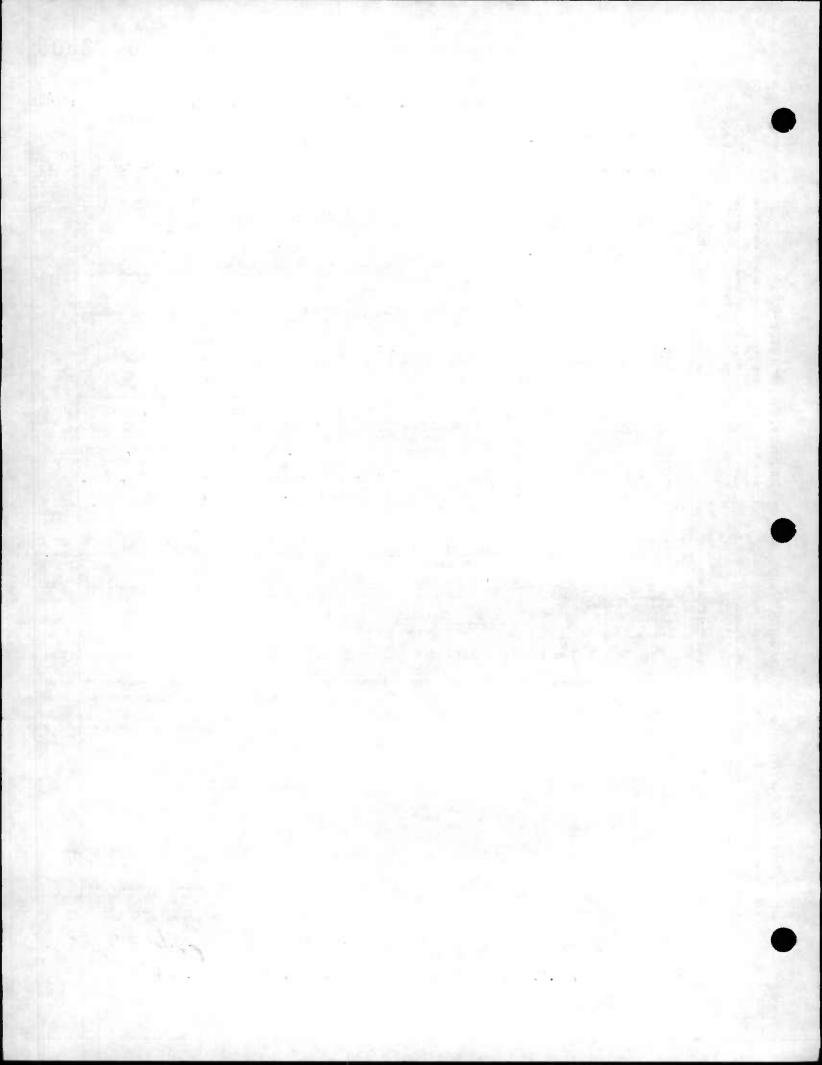
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Physician /Medical	Donna McGee	July	10. 2000	7:45				
Examiner	4a Facility Nema (If not institution, giva street and number) 4b.	City, Town, or Location of Death						
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tem 27 te marked other than other treumatic event, the M To Be Comp		8. Mothar's Name (First, Middle,	, Maiden Surnama)	- 1				
arked on To B	Russell Martin	Pearl Moore						
E E			per, City or Town, Stata, Zip Coda)					
ther tr		enue Baltimore	Maryland 2121	1				
If item 27 or other to	20a. Method of Disposition 1 ☐ Burial 2 🏋 Cramation 3 ☐ Ramoval from Stata	Data	20c. Location - City or Town, St	ata				
경험	4 Donation 5 Othar (Specify) Baltimore-Washingto	on Cr. 7/14/00	Laurel, Marylan	nd				
mportant: any injury ance.	21. Signature of Funeral Service Licensee 22. Nama and Address							
importal eny inju page.	Burgee-He	enss-Seitz Fu	uneral Home,	Inc.				
	Grand Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant Grant	s Road Balti	Lmore, Maryla	nd 2				
-	23 Pad Fenter the disease, of complications the value of the death. Do not antar the mode of dying, nock, or heart failure. List only one cause of each line.	such as cerdiac or raspiratory a	Irrast, Appro	ral Between t and Death				
sician				may				
edical ıminer	tmmediata Causa (Final disease or condition resulting in death) a.		i All	lus				
BOOK I	Due to (or as a consequence of):			many				
in a	a b AF		ille	au				
sicien and burial-transit	Sequentially list conditions, Due to (or as a consequence ot):							
	Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury c.							
\$ ª	that initieted avants resulting in death) Last Dua to (or as a consequence of):	IVANTS Due to (or se a consequence of):						
5								
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igned by the ell be deteched for by Physic	Part II. Other significant conditions contributing to death but not rasulting in the underlying ceuse given	in Part I. 23b. Dld	tobacco use contribute to the c	ause of de				
Phy t		10	Yes 2 No 3 Probably	4 Unkr				
sete hes been signe pege 2 should be c Completed by		24a. Was	s an autopsy 24b. Were aut available					
S S De			completic of death?	on of cause				
e hes ege 2		10	Yes 2 No 1 Yas	20 No				
certificate rector, per	25. Was casa ratarred to medical	26. Place of Death (Check only						
	axaminar? 1 Yas 2 No							
£ m	27. Manner of Death 28a. Data of Injury 28b. Tima of 28c. Injury a		how injury occurred					
the funeral the funeral cation:	Livaturat 3 Lirationing	as 2 No						
otor y the	3 Suicida 6 Could not be 28e. Place of Injury - At home farm street factory office		(Straat and Number or Rural Rout	a Number				
al Director: After tied in by the funeral Certification:	4 Homicida determined building, afc. (Specify)		wn, State)					
1 0 U	29a. Certifier 1 Cartifying Physician: To the best of my knowledge, death occurred at the time.	data and place and discussion						
To the Funeral Director: A completely filled in by the fi	(Check only 2 Medical Examiner: On the basis of axamination and/or invastigation, in my opin			ausa(s)				
Med Med	and marries desired.	number	20d Data signed (Month Day)	(ear)				
28	29b. Signatura and titla of certifier 29c. Licansa r	1/-1/	29d. Data signed (Month, Day, Y	ear)				
6 17	marcha C. Laiminelo 05%	018	7-11-00					
7.	30. Nama and addrass of person who complated ceusa of daath (Itam 23a) (Typa, Print)	4.00						
W /	3004 & Northean Parkway, Breetimes MI	7 21214	77. 14					
State	31. Data tiled (Month, Day, Year) 32. Registrar's Stonatura	/						
Registrar	11 1 4 2000 Januar 10 popular							
	MH 1 07 / UUU / / /							



Please Type or Print in Black Indelible ink. Assure Ali Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 00 22389

			Ce	rtifica	te of L	Death		Re	g. No.		
Decedent's Name (First, Middle				- 19			M	ate of Death onth	Day	Year	3. Time of Death
		cherine	J.	M.	iller			ly 9,	2000		9:15 PM
4a Facility Name (If not Institution	410	ımber)					n, or Location		4c. County		
5306 Valiquet				. If I lade	r 1 Year	Balt1	more C	-		N/A	
5. Sociel Security Number	6. Sex 1 ☐ M 2 ☑ F		s. last birthdey, Yrs.	Months			Min. (M	te of Birth lonth, Day,	Year)	9. Birth	place (Stete or Foreign
216-74-6064 Usuel Residence of Decedent		62_					Ap.	LIT TO	0,1936	Penn	sylvania
10a. Stete 10b. County		10c. 0	City, Town or L	ocation				100		1	10d. Inside City Limits
Maryland N	I/A				Bal	timor	e City				13⊠ Yes 2 No
10e. Streef and Number	y n			10f. Zi	p Code		0 0 2 0 7	10	g. Citizen of W	/hat Cour	ntry?
5306 Valiquet	Ave.					2120	6		United	Sta	ites
11. Marifel Status	12. Was Dec	cedent Ever in	U,S. 13.	Wes Dece	dent of H	ispenic Origi	n? (Specify Y Puerto Rican	es or No-			can fndian,
1₺ Never Merried 2 Merr	ried Armed F	21 No		1 ☐ Yes		Specify:	rueno rican	, etc.)		k, White,	etc.
3 Widowed 4 Divorced	If Yes, G Yeer or I	Detes:		1 LI TUS	2451 NO	<i>Specify</i> :			Specify:	W	hite
15. Deceden (Specify only highes	nt's Education)	16a. Dece	dent's Usu	el Occupa	ation during most o	of working	1	6b. Kind of Bu	siness/In	dustry
Elementary/Secondary (0-12)		(1-4or 5+)	lifa.	DO NOT	ise retired	1)					
N/A			De	epende	ent					N/A	1
17. Father's Name (First, Middle,	Last)				4	18. Mother	s Neme (Firs		laiden Sumem	Θ)	
Not	Known			4-1				Not 1	Known		
19e. Informant's Neme/Relations				-					City or Town,		
Dareen Barrios	(Caregiv			10.00		Bounda:	ry Roa		ndalk,		
20a. Method of Disposition 1 ☐ Burial 2XDCremetion	3 DRemovel from		. Plece of Disp cemetery, cre	osition (Ne metory or	other plac	e)	Da	te 2	Oc. Location -	City or To	own, State
4 Donetion 5 Other (S		H	illtop	Serv	ice (Corp.	7/12/2	000	Towson	n, Ma	ryland
21. Signature of Juneral Service	Licensee)	0	2	2. Neme e	nd Addres	ss of Facility	ral Hor	no of	Dunda 1	le T	na
Alred.	Y Kee	9		7922	Wico	7,170	Dund	11c N	(arreland		1222
23e. Pert1. Enter the disease, of shock, or hear failure. List	complications that	ceused the de	eth. Do not en	nter the mo	de of dyin	g, such as ca	ardiac or resp	piretory arre	st,	4 2	Approximete Interval Between
SHOCK, OF HOOF JAMES	Control Course On	oour ino.								- 1	Onset and Deeth
Immediate Ceuse (Finel disease or condition	26										
resulting in death)	a. MyO		Infar								5 Mins.
	. Down	n's Svr	drome								62 Years
Sequentially list conditions,	6.	-	(or es a conse	quence of):						VZ TEALS
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Sei	zure Di	sorder								5 Years
that initiated events resulting in death) Lest	С.	Due to	(or es e conse	quence of)	:						
	Hype	othyroi	diem								5 Years
	d. 117 p.	octivito:	QI SIII		1						5 Tears
Pert ii. Other eignificant condition	one contributing to	deeth buf not r	esulting in the	underlying	ceuse giv	en in Pert I.		23b. Did tol	bacco use cor	ntribute t	o the cause of death?
							3.1	1 ☐ Ye	NO XIX O	3 Pro	bably 4 Unknow
							_			1	
							2	4a. Wes an		a\	/ere eutopsy findings vailable prior to
										of	ompletion of cause death?
								1□ Ye	s XXNo	1	☐Yes 2☐ No
25. Wes cese referred to medical	ıl					26. Place o	of Deeth (Che	eck only one	B)		
exeminer? 1 ☐ Yes 2ऄ No	Hospitel: 1	Inpatient 2	☐ ER/Outpatle	ent 3 D	OA Oth	er: 4 Nurs	sing Home	Reside	nce 6 Othe	er (Speci	ity)
	28a. Date	of Injury oth, Dey Year)	28b. Time (of	28c. Injur	y at	28d. [Describe ho	w injury occum	red	
27. Manner of Death	19	,,,	1	М		Yes 2□N	lo				
27. Manner of Death 1 🖰 Natural 5 🗆 Pendin 2 🗀 Accident investig			home, ferm, s	treet, fecto	ry, office			ocation (Str		er or Rur	rel Route Number,
27. Manner of Death 1 ☐ Natural 5 ☐ Pendin	not be 28e. Plec										
27. Manner of Death 1 Natural 5 Pendin 2 Accident investig 3 Suicide 6 Could	not be 28e. Plec	e of Injury - At ding, etc. (Spe	City)								
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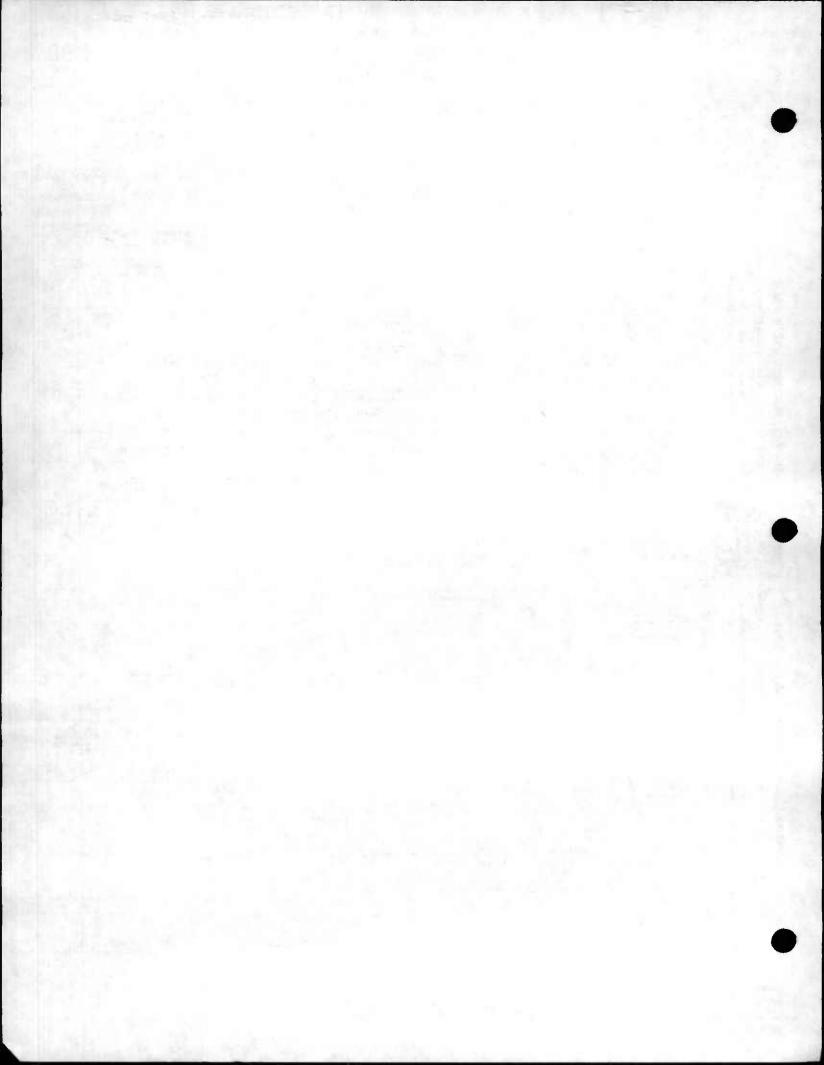
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene [] []

Certificate of Death 2. Dete of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month **Physician** 6 2000 July 10:15PM June Marie Morell /Medical 4a Facility Name (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth Examiner Stella Maris Timonium Baltimore If Undar 1 Yaar | If Under 24 Hrs. Birthplaca (Steta or Foralgn Country) 5. Social Security Number 7. Aga (In yrs. last birthdey) 8. Data of Birth (Month, Dey, Year) **Funeral** Deys Hours Months 1 M 2 X F Director 173-18-9580 83 June 29 1917 Pennsylvania Usual Residence of Decedent Peges 1 and 2 should be filed within 72 hours efter death with the Menyland the Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits d other than "natural", or itema 23a or 28a-f ahow event, the Madical Examiner must be notified at 1 Yes 2 No Funeral Director Baltimore Towson 10f. Zip Code 10g. Citizen of Whet Country? 10e Street and Number USA 21286 500 Virginia Ave. #601 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indien, Bleck, White, etc. 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Merried 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: Completed by White 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Own Home 12 Homemaker 18. Mothar's Nema (First, Middle, Meiden Sumeme) 17. Father's Neme (First, Middla, Last) Be Loretta Heilman Oliver Schwitzer 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Department of Health a Important: If New 27 is any injury or other tra 800 Southerly Ct. Towson, Md. 21286 Mr. Thomas Morell/Son 20b. Place of Disposition (Neme of cametery, cremetory or other plece) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 □ Cramation 3 □ Removal from State 7-10-00 Pittsburgh, Pa. Mt. Royal Cemetery 4 ☐ Donetion 5 ☐ Other (Specify) 21. Signature of Funerel Service License 22. Name end Address of Fecility Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease of complications that extract the deeth. Do not enter the mode of dying, such as cerdiac or respiretory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervat Between Onset and Deeth **Physician** Hapalie Cercinome /Medical tmmediate Ceuse (Finel disease or condition resulting in deeth) Examiner Due to (or es a consequenca of) Examiner The law requires that the deeth certificate be executed burial-tran Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or es e consequence of): Box 68760. attending physician for use es the buria Physician/Medical Dua to (or as a consequence of) P.O. Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributa to the ceues of death? 1 Yes 2 No 3 Probably 4 Unknown Popertension Division of Vital Records. þ 24b. Ware eutopsy findings aveileble prior to completion of cause of deeth? 24e. Wes an eutopsy performed? Completed Deprossion-After this certificate hes Alrice Fibrilletion 1 Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

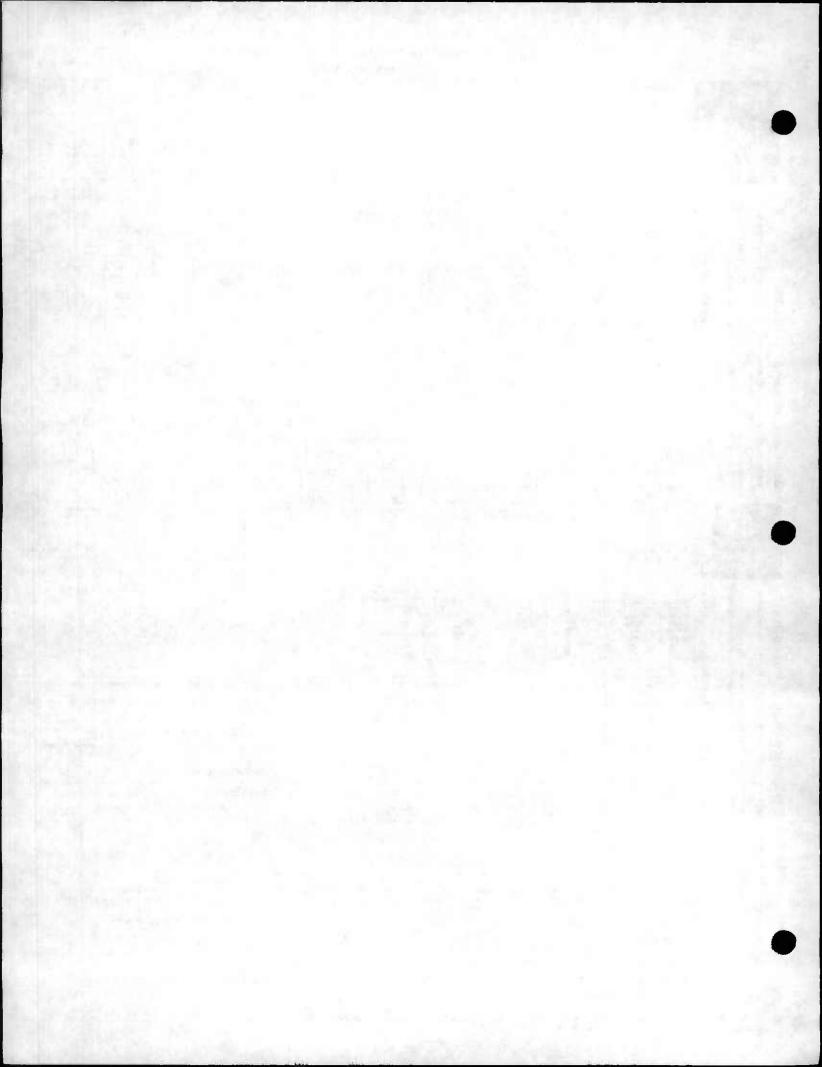
To the Funeral Director: After this certifica completely filled in by the funeral director, I 25. Wes case referred to medicat examiner? Be 26. Place of Deeth (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yas 2 No Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menger of Deeth 28c. Injury et Work? 28d. Describe how injury occurred 1 Naturat 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homleide To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Cartifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 053283 30. Name and address or person who completed cause of death (Item 23a) (Type, Print) Soull 13211. more MO 21230 Henores 31. Date filed (Month, Day, Year) 32. Registrer's Signeture State JUL 1 4 2000 Registrar



			Certificat	e of Death		Reg. No.	0 22331
Physician	Decedent's Nama (First, Middle, Late Covdel)	maith			2. Data of De	Day 21	Year 2 PM
/Medical Examiner	4a Facility Nama (If not institution, give	a street and number)		4b. City, Town, or	Location of Peat	h 46. County	of Death
	925 Wilma	ont Ct.		Balti	more		NA
Funeral	5. Social Security Number 6. S	Sex 7. Age (In yrs.	Yrs. If Unda Months	r 1 Yaar If Undar 24 Hrs Days Hours Min.		Year) 90/	9. Birthplaca (State or Forai
Director	Usual Rasidence of Decedent	12			uury.	24/1/06	Maryland
a how	10a. Stata 10b. County	1/A 100 GH	y Jown or Location				10d. Insida City Limi
vith the Ma to 284-1 s be notified Director	Maryland /V	/17 /0	SHIIM	ore		40. 02	
		ent ct	10f. Zi	2/202		10g. Citizen of V	S,A,
iffer death v items 234	11. Marital Status	12. Was Decedant Evar in U. Armed Forcas?	S. 13. Was Dace if Yas, spe	dent of Hispanic Origin? (S cify Cuban, Maxican, Puar	Specify Yas or No to Rican, atc.)	o- 14. Rac Blac	e - American Indian, ik, Whita, atc.
raf, or i	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yas 2 ☐ No If Yes, Give Yaar or Datas:	1 ☐ Yas	2 No Specify:		Specify	Black
"natural", allea Exer	15. Decedant's Ed (Specify only highast gra	lucation ida completed)	16a. Decedent's Usu (Giva kind of wo	ork dona during most of wo	rking	16b. Kind of Bu	sinass/Industry
ygiena. Ner than "naturi rt, ma Medical	Elamantary/Secondary (0-12)	College (1-4or 5+)	SHI.	ent		Co	harl
THE O	17. Fathar's Nama (First, Middle, Last)		5140		ma (First, Middle	, Maiden Surnam	a) /
marked or umatic eve	William A	· Laws.	1	Jaco	ruelin	re N	laith
and is me	19a. Informant's Name/Ralationship	Typo, Print) (mother)	19b. Malling Addras	s (Street end Number or R	Dral Routa Numb	per, City or Town,	Stete, Zip Coda)
item 27 r other tr	20e. Method of Disposition	ne Marth	7d5 VV	IMONT	Data,	Salto.	City or Town, Stata
0	1 Burial 2 Cramation 3	Ramoval from Stata	cematary, cramatory or	other placa)	7/17/2000	R. /	L MA
투 분 분	4 Donation 5 Other (Specify 21. Signature of Funeral Service/Licen		22. Nama a	nd Addrass of Facility	1,000	M	O. 141a.
Dep and and and and and and and and and and	* (MARAK)	y 4111	1/Josep	n L. Rys	s, Fun	eral, H	ome 21211
	23a. Parth Enter the disease, or complete, or heart failure. List only	plications that caused the deat	h. Do not antar tha mo	da of dying, such as cardia	c or raspiratory	parto,	Approximata Approximata
hysician	snock, or heart taylure. List only	ona cause on each line.					Intervel Between Onsat and Daath
/Medical xaminer	Immedieta Causa (Final disaasa or condition	me	edullobla:	stoma			4 years
	rasulting in death)		or as a consequance of)				
n and ial-transit Examiner		b					
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physician and is the burial-transit edical Examír	cause. Enter Undarlying Ceuse (Diseese or injury that initiated avants rasulting in death) Last	cDua to (c	or as a consequence of)				
nding pt usa es t n/Med		d					
ing law requires that the deem certificate be executed at a hes been signed by the attending physician and page 2 should be deteched for use as the burial-transit Completed by Physician/Medical Examir	Part II. Other significant conditions of	ontributing to death but not ras	sulting in the underlying	causa givan In Part i.	23b. Did	tobacco use co	ntributa to the causa of deat
at ma					10	Yes 20 No	3 Probably 4 Unknow
Signe De d			7.16				24b. Were autopsy finding
cata has been single page 2 should					24e. Wa: perf	s en autopsy ormed?	available prior to complation of causa
ge 2						-500	of death?
	25. Was casa rafarred to medical			26 Place of Da	ath (Check only	Yas 2 X No	1 Yas 2 No
nyaice his cent direct	axaminar?	Hospitel: 1 Inpatient 2	ER/Outpatient 3 D	Other		idence 6 Oth	er (Specify)
	27. Mannar of Death	28a. Data of Injury (Month, Day Year)		28c. Injury at Work?	_	how Injury occur	
or: After the funer	1 Natural 5 Pending 2 Accident investigation	1	М	1 Yas 2 No			Sec. 17 (b) 65s
an or attenting Proyectent: as after death. If Director: After this certific ed in by the funeral director, Certification: To Be (3 Suicida 6 Could not be detarmined	28a. Place of Injury - At he building, etc. (Specif	ome, farm, straat, factor (y)	y, offica	28f. Location City or To	(Streat and Numb own, Stata)	per or Rurel Routa Number,
to the trouptus or Autending Pri With 24 hours after desti- completely filled in by the funeral Medical Certification:	(Check only 2 Medical Exam	ysfcian: To the best of my kno niner: On the basis of examina	owledge, deeth occurred	at the time, dete end plec	e, and due to the	ceuse(s) end ma	nner as stated. and dua lo tha causa(s)
thin 2 the mplet	one) 29b. Signatura and titla of certifier	and mannar stated.		c. Licansa number			d (Month, Day, Year)
\$ F 8	250. Signatura and this of certifier	10 11	29	D0 055194	THE	7/12	
X	30. Nama and addrass of person who	Completed cause of death (Item	n 23a) (Tuna Print)	٠٠ ارد ١٠٠		7/12	1
()				ene St Rm N	15216 P	althurore	MD 21201
State	31. Data filed (Month, Day, Year)	32. Registrar's Signe			10 00		
Registrar	1111 4 4	2000 here	na B	Sparks			
H 16 Rev 6/95	JUL 14	2000		1			

ORIGINAL



signed by the a funeral s after deeth.

I Director: A
od in by the fu To the Hospital o within 24 hours aff To the Funeral DI completely filled in

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certificate

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After

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Attending Physician:

5

00-3668-005

Physician/Medical 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 □ Yee 2 No þ 24a. Was an autopsy performad? Completed 25. Was case rafarred to medical axaminer? Be 26. Place of Death (Check only ona) To Hospitat: 1 ☐ Inpatiant 2 ☐ PER/Outpatient 3 ☐ DOA Othar: 4 Nursing Homa 5 Rasidanca 6 Other (Specify) 11X Yes 21 No 28a. Data of Injury 7-4,00 Certification: 27. Mannar of Death 28b. Tima of A 28c. Injury at Work? 1 | Natural 5 Pending Invastigation 6:30 1 Yas 2 X No 2 ☐ Accident 6 Could not be determined 3 ☐ Suicida 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) RESIDENCE 4 ☑ Homicida 1 Certifying Phyelctan: To the best of my knowledga, daath occurred at tha time, data and place, and dua to the causa(s) and manner as stated.

Medical Examiner: On the basis of examination and/or invastigation, in my opinion, daath occurred at the time, data and place, and dua to the causa(s) and manner stated. 29a. Cartifiar edical (Check only one)

24b. Ware autopsy findings available prior to complation of cause of death? 2M No

3. Tima of Death

10d. Inside City Limits

Approximata tntervat Between Onset and Death

3 Probably 4 Unknown

1 Yas 2 No

7:00 A.M.

28d. Dascribe how Injury occurred

SUBJECT WAS ASPHYXIATED

28f. Location (Streat and Number of Bural Boute Number City of Town, State) 936 BFAVER BANK CIRCLE, TOWSON, MD.

July 05, 2000

29c. Licansa number 29d. Data signed (Month, Day, Year)

30. Nama and addrass of person who complated causa of daath (Itam 23a) (Type, Print)

M.D.

111 Penn Street, Baltimore, Maryland 21201 M.1)

State Registrar

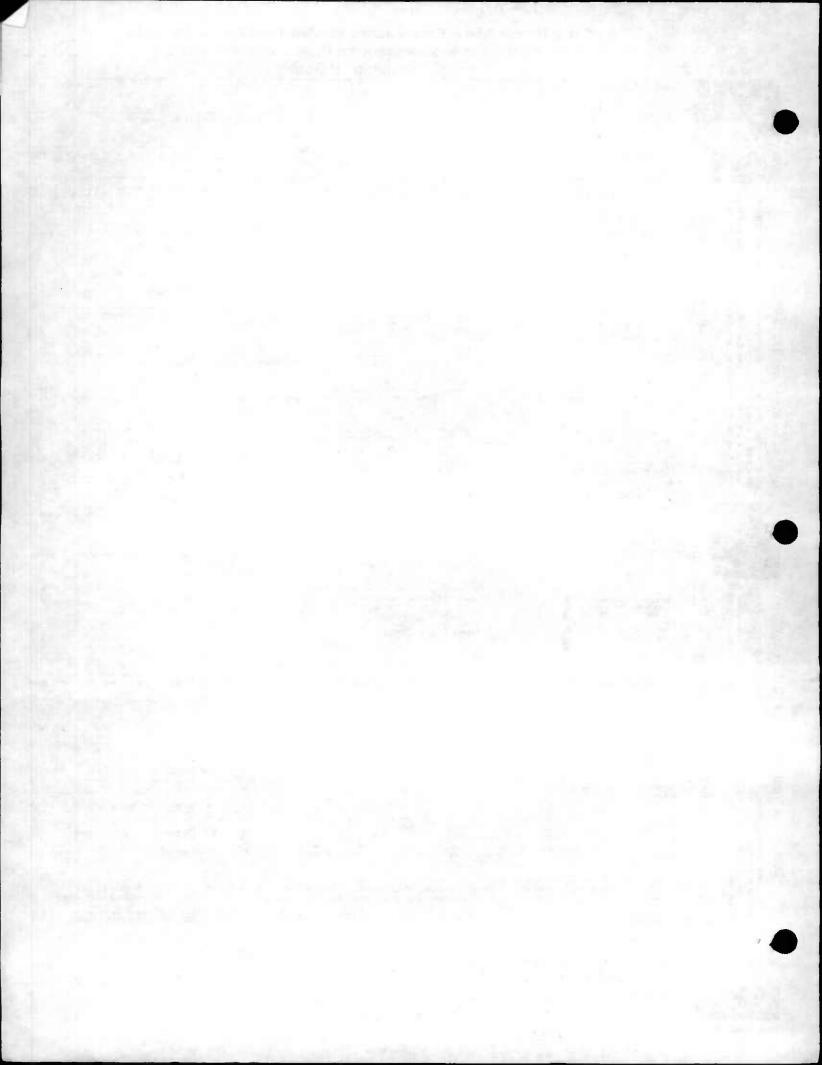
31. Data filed (Month, Day, Year) AUG 0 1 2000

MARY CT. RIPPLE

29b. Signatura and title of certified

32. Registrar's Signatura Thyer

O.C.M.E.



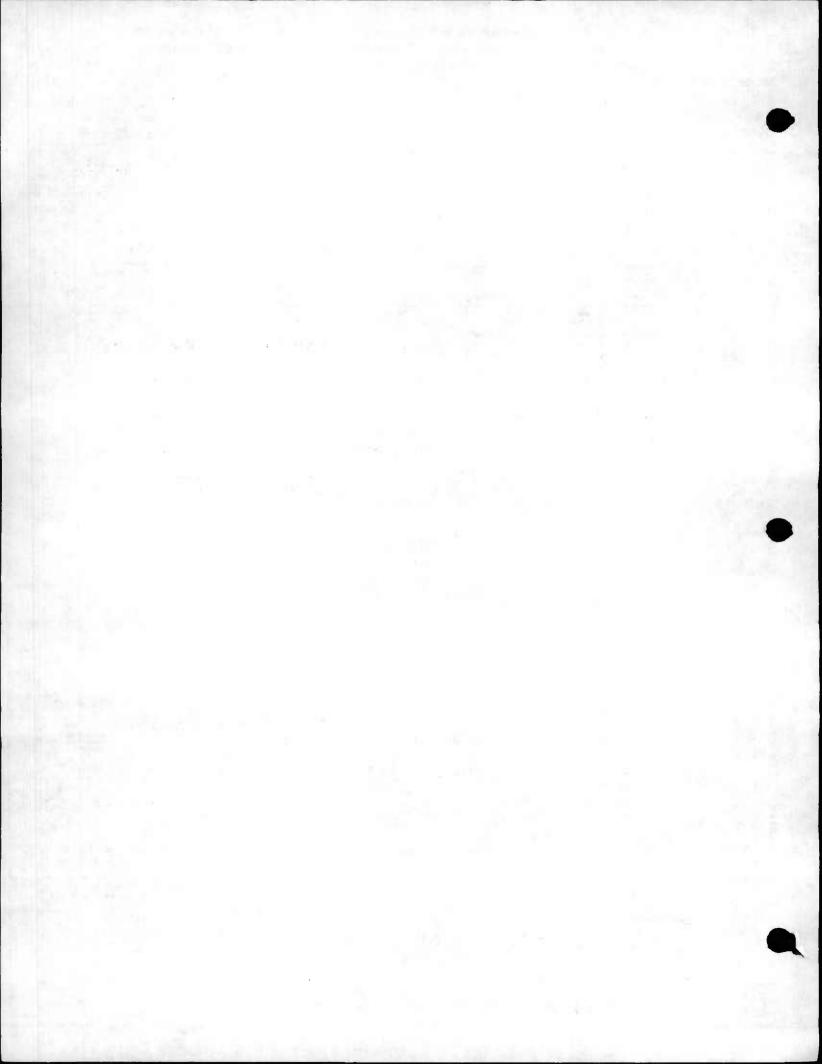
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22393 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death Day Month **Physician** Mary Dove Olsen Ju1y 12 2000 12:24 pm /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospice House of the Chesapeake Anne Arundel Linthicum If Under 1 Year | If Under 24 Hrs. Birthplaca (Stata or Foraign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Data of Birth (Month, Day, Year Funeral Days 1 M 2 X F Yrs 90 Director 214-30-3429 May 4, 1910 Maryland Usual Rasidence of Decedent 10a. State 10c. City, Town or Location 10b. County 10d. Insida City Limits 7 is marked other than "natural", or hame 23a or 28e-f eho traumetic event, the Medical Examinar must be notified at 1 ☐ Yes XIX No Director MD Anne Arundel Arnold 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? 738 Match Point Drive 21012 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indien, Black, Whita, atc. 1 Nevar Married 2 Married 1 ☐ Yas 2X No If Yes, Giva Year or Datas: Baltimore, Maryland 21215-0020 1 Yes 2√No Specify: Specify: à White 3 ☐ Widowed ♣️ Divorced Completed 16a. Decedent's Usual Occupation (Giva kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Business/Industry Elamantary/Secondary (0-12) College (1-4or 5+) 8 Income Tax Supervisor State of Maryland Ages 1 and 2 should be file observant of Health and Mental Hys, any injury or other 27 is marken. marked other 17. Fether's Nama (First, Middla, Last) 18. Mother's Nema (First, Middle, Maiden Sumama) å 2 William Dove Susie Virginia Brown 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 738 Match Point Drive, Arnold, MD 21012 Ellen V. Foxwell (Daughter) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete 07/17 1 Burial 2 Cremation 3 Removal Irom Stata Baldwin Cemetery 4 ☐ Donation 5 ☐ Othar (Specify) Millersville, MD 2000 21. Signature of Funaral Sarvice Licenses 22. Nama and Address of Facility
Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401 Approximata Interval Between Onset and Death 23a. Perti. Enter the diseese, or conshock, or haart failura. List only blications that caused the death. Do not enter the mode of dying, such es cardiac or respiretory errest, and cause on each line. **Physician** Immedieta Causa (Final diseasa or condition resulting In death) /Medical Carcinoma of Pancreas 1 month Examiner Due to (or as a consequence of): Examiner anding physician and use as the burial-transit Sequantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Dua to (or as a consequence of): Box 68760 Physician/Medical that initiated events rasulting in death) Last Dua to (or as a consequence of) P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? à 1 ☐ Yas 2 ☐ No 3 Probably 4 Unknown signed b Deep Vein Thrombophlebitis Records. by cate has been significant category. 24b. Wera autopsy lindings available prior to complation of cause of death? Completed 24a. Was an autopsy performed? Arteriosclerotic Cardiovascular Disease 1 ☐ Yas 2 No 1 ☐ Yes 2 ☐ No certificate Old Cerebrovascular Accident Division of Vital Be 25. Wes casa ralarred to medical 26. Place of Deeth (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Nother (Specific OSPICE Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 2 1 Yas 2 No this funeral 27. Mennar of Death Certification: 28a. Deta of Injury (Month, Day Year) 28b. Tima of 28c. Injury at Work? 28d. Describe how injury occurred I or Attending P after death. Director: After I 1 Naturel 5 Pending invastigation Home 1 Yas 2 No 2 Accidant 3 Suicide 6 Could not be detarmined 28e. Place of Injury - At homa, farm, street, lactory, office building, atc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stata) in by 4 Homicide To the Hospital within 24 hours a To the Funeral D completely filled cal 29a. Cartifiar 15 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, end due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Data signed (Month, Day, Year) D14160 07/12/2000 30. Nama and addrass of person who completed cause of death (Item 23a) (Type, Print) Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225 32. Registrar's Signature 31. Deta liled (Month, Day, Year) State

DHMH 16 Rev 6/95

Registrar

14 2000

JUL



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22394 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Dey 2000 Physician Month
JULY 6 Stephen M. O'Connell, Jr. 12:40 AM /Medical 4e Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner MEDICAL CENTER GREATER BALTIMORE BALTIMORE
9. Birthplace (State or Foreign Country)
MA TOWSON
If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year)
Mar. 8, 1914 5. Social Security Number 6. Sex 1 M 2 □ F **Funeral** Days Hours 213-03-0613 86 Yes Director Md. Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ahow 10d. Inside City Limits permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryla Department of Health and Mentel Hygiene. Important: if Item 27 is marked other than "natural", or Items 23s or 28s-f show they futury or other traumatic event, the Medical Examiner must be notified at page. 1 ☐ Yes 2 No Director Md. Baltimore Towson 10e. Street and Number 10f. Zip Code 10a. Citizen of Whet Country? #705 205 E. Joppa Rd. Funeral 21204 USA 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates: 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 1 Never Married 2 TMerried 1 Yes 2 No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working tife. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementery/Secondary (0-12) 12 Self Employed Paving Cont 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stephen M. O'Connell, Sr. Louise P. Schaudron 19e. Informent's Neme/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) Mrs. Mary E. O'Connell/wife 205 E. Joppa Rd. #705 Towson, Md. 21204 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 D Burial 2 Cremation 3 Removel from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Memorial 7/8/00 Timonium, Md. 22. Name and Address of Facility
Ruck Towson Funeral Home, Inc. ture of Funeral Service by 1050 York Rd. Towson, Md. 21204 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feiture. List only one cause on each line. Approximate Intervel Between Onset end Deeth **Physician** Immediete Cause (Final disease or condition resulting in deeth) /Medical ARDIOGENIC Shock Examiner Physician/Medical Examiner 40 curdial attending physician and for use as the bunal-transit Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting In death) Last ar Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? signed by 1 Yea 2 No 3 Probably 4 Junknown þ cata has been sig 24b. Were eutopsy findings available prior to completion of cause of death? Completed 24e. Wes en eutopsy parformed? 2 2 No 1 ☐ Yes 2 ☐ No certificate To the Hospital or Attending Physician: within 24 hours after deeth.

To the Funeral Director: After this certifica completely filled in by the funeral director, t Be 25. Wes case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury et Work? 1 Neturel 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, fectory, office building, etc. (Specify) 4 Homicide

68760 P.O. Box Records, Division of Vital

Connell,

31. Date filed (Month, Day, Year) Registrar

29e. Certifier (Check only one)

29b. Signature end title of certifier

anald de

SCHECHTER, MD 32. Registrar's Signature

meanta, M

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6565 N. Churler St. Suite 615 Baltimore, MD 21204 ooch)

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and plece, and due to the ceuse(s) and menner as stated.

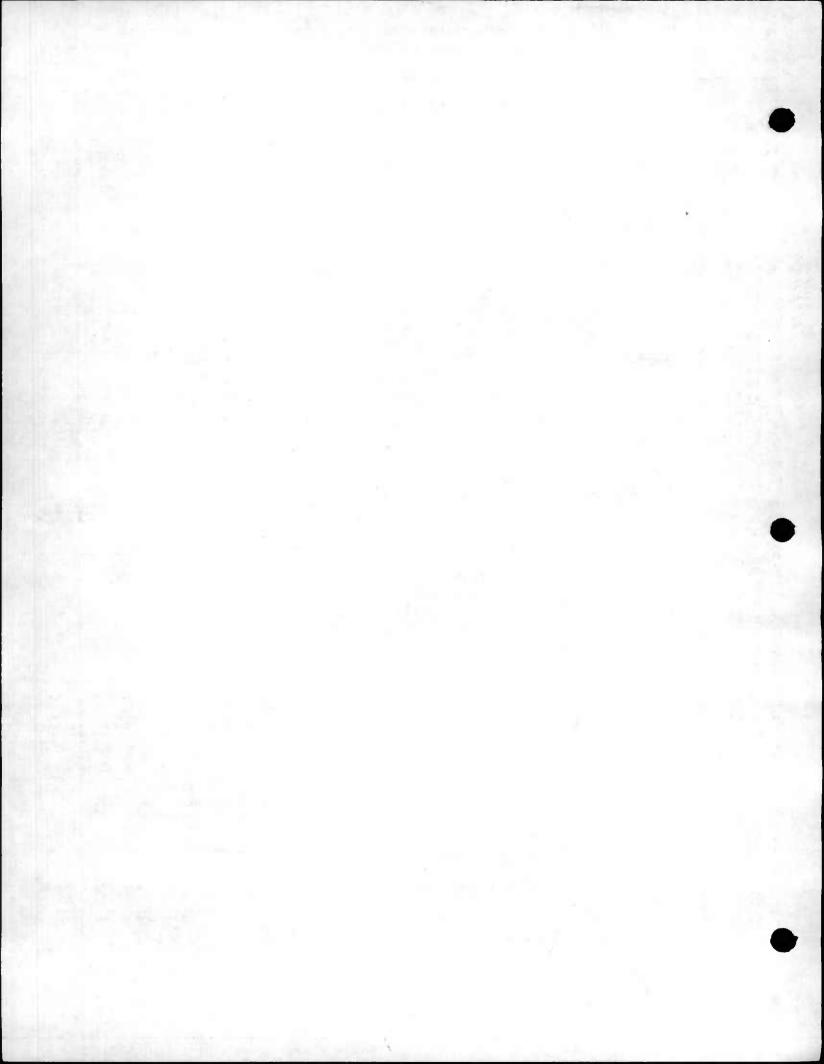
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date end plece, and due to the cause(s) and manner stated.

29c. License number

D0032338

29d. Date signed (Month, Day, Year)

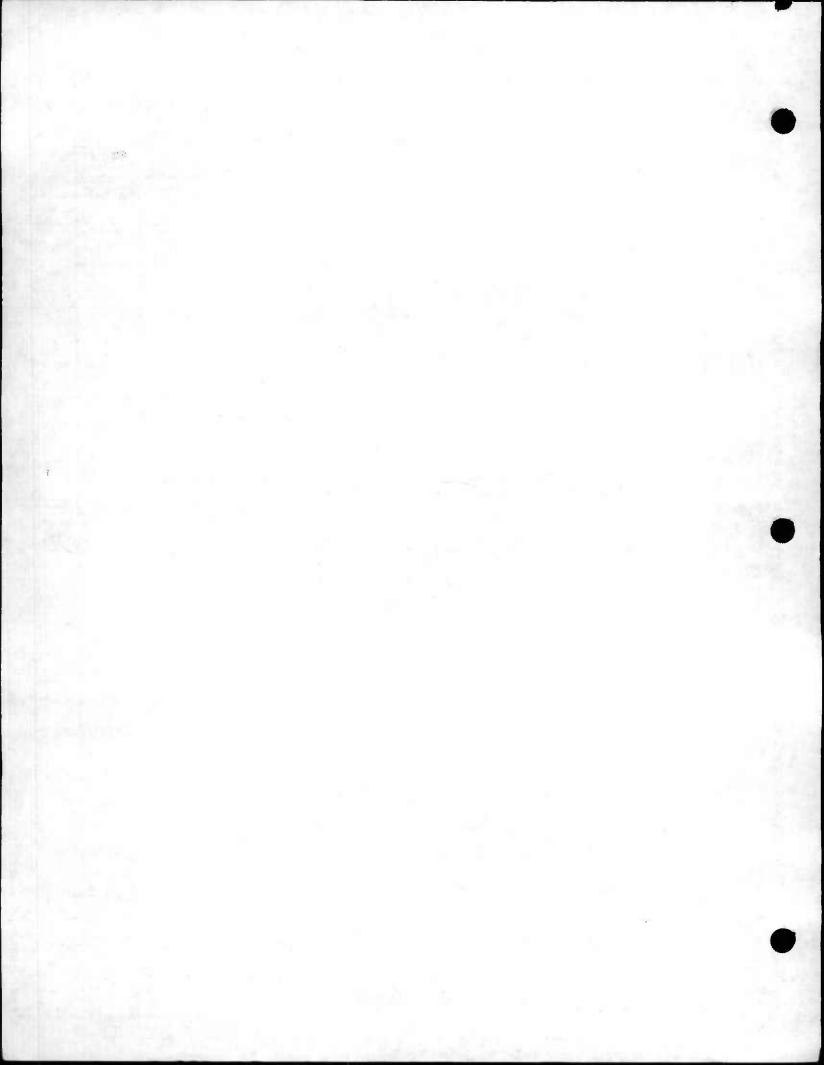
7.6.2000



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middla, Last) 2. Dete of Death **Physician** 22:45° 2000 DINKNE Jule DONNEU /Medical 4b. City, Town, or Location of Death 4e Fecility Name (If not institution, give street end number) 4c. County of Deeth Examiner Baltimore he Johns HOPKINS If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) If Under 1 Year Birthplece (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) **Funeral** Months Deys 190-38-9909 15 M 2□ F 53 Director March 12, MD Usual Residence of Decedent the Maryland 10e. Steta 10c. City, Town or Location 10d. Inside City Limits or 28a-f show other traumatic avant, the Medical Examinar must be notified at PA Lancaster Yas 2 No Lancaster, PA Director 10e. Sireet and Number 10f. Zip Code 10g. Citizen of What Country? with 505 Locust Street 17602 United States Nerns 23a Funeral Peges 1 end 2 should be filled within 72 hours after death nent of Health end Mentel Hygiene. Wes Decedeni of Hispanic Origin? (Specify Yes or No-iff Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S Armed Forces? 14. Rece - American Indien 11 Maritel Stetus 1 Yes 2 No If Yes, Give Yeer or Detes: Bleck, White, etc. 1 ☐ Never Merried 2X Merried Maryland 21215-0020 "natural", or 1 Yes 2 No Specify: Black Specify. þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondery (0-12) College (1-4or 5+) Lukens Steel Company Steel Worker 12 0 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maidan Surname) Be of Health end Mentel James Pinkney Louise Jenkin 0 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19e. informent's Neme/Raletionship (Type, Print) Mary Pinkney 505 Locust Street, Lancaster, PA 17602 Baltimore, 20b. Pleca of Disposition (Name of camatery, cramatory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete permit. Peges Department of Important: If it any Injury or o 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removel from State Mellingers Mennonite Cemetery July 14, 2000 Lancaster, PA 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme end Address of Fecility Charles L. Stevens Funeral Home, Inc. 21. Signeture of Funerel Service Licensee Victor P. Doda, Jr. 1501 East Fort Avenue, Baltimore Maryland 21230 Approximete Interval Batween Onset and Deeth 23a. Pert1. Enter the diseesa, or complications that cause of shock, or heert teilure. List only one cause on each line math. Do not anter the mode of dying, such es cardiec or respiretory arrest, **Physician** /Medical Immediata Cause (Final year disaese or condition resulting in deeth) **Examiner** Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initiated events rasulting in death) Last bunial-tran and Due to (or es e consequenca of) Box 68760. physician Physician/Medical the Due to (or es e consequence of): signed by the attending I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? of Vital Records, P.O. No No 1 Yes 3 Probably 4 Unknown Completed by 24b. Were eutopsy findings evailable prior to 24a. Wes en eutopsy performed? peen s completion of cause of death? this certificate hes 2 No Attanding Physician: 25. Wes case referred to medical examiner? Be 26. Place of Death (Check only ona) Hospitel: Inpatient Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 28e. Dete of Injury (Month, Day Year) 27. Menper of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division Neturel 5 Pending investigation death. 1 Tyes 2 No spital or Attandil nours efter death. neral Director: A 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, State) 3 ☐ Suicide Plece of injury - Ai home, ferm, streei, fectory, office building, atc. (Specify) 4 Homicide To the Hospital o within 24 hours of To the Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated. Medical 29a. Cartifier completely (Check only one) 29b. Signetura end title of certifier 29c. License number 29d. Dete signed (Month, Day, Year) -000 30. Name and eddress of parson who completed cause of deeth (Item 23a) (Type, Print) NEUSON 106 PALTIMORE, ND JOHNIFOR MURERS MD 400 N 31. Dete filed (Month, Day, Year) 32. Registrer's Sign State JUL 14 2000 Registrar



00-3659-510 jhm DAVI PE

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible.

AVID		State of Maryland /	•		Mental Hy	giene ()	223	96
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Physician	1. Decedent's Name (Pirst, Middle, Elist	Parre			2. Date of Do Month JULY		Year	of Death
/Medical Examiner	4e Facility Neme (If not institution, give	street and number)		4b. City, Town, or	Location of Deal			L4 PM
	HARBOR HOSPITÄL			BALTIMO		1	VIA :	
Funeral	5. Social Security Number 6. Se	7. Age (In yrs. last	Yrs. If Under	or 1 Yeer If Under 24 Hrs Days Hours Min.		ay. Year O/	9. Birthplace (State	
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020 on atte	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 No If Yes, Give	1□ Yes		,,	Agecity:	1. 1	
	15. Decedent's Edu	Yeer or Dates:	Sa. Decedent's Usi			16b. Kind of Bus	0-01	ericar
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altimore	4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens	e O O	22. Name a	nd Address of Facility	1 1/0000	Lanso	towne,	Ma.
B Popular	Dana Ohi	& KIM	Joses	1 1 11	s Fun	eral He	me	1/
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Physician							Onset an	d Death
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death)	ALCOHOL AND NARO						-
Je Le Le Le Le Le Le Le Le Le Le Le Le Le		Due to (or es	a consequence of):				
760, be executed sician and burial-transit all Examiner	Sequentially list conditions,	Due to (or as	a consequenca of	:	7 1 1 1 3			
2 g in a	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that Initiated events							
0 = = 0	resulting in deeth) Last	Due to (or es	e consequenca of)					
Il Records, P.O. Box 6. The law requires that the death certific rate has been signed by the attending p. page 2 should be detached for use as Completed by Physiclan/Me		J						
O. I he des	Pert II. Other significant conditions con	tributing to death but not resulting	In the underlying	cause given in Part I.	23b. Did	tobacco use con	tribute to the caus	of death?
that the ned by the detache					1	Yes 2 No	3 Probably 4	Unknown
Records, P.O. he law requires that the de a has been signed by the tige 2 should be detached ompleted by Physic						s en eutopsy ormed?	24b. Were eutops evailable prid	sy findings or to
law re as be as be appled					,		completion of death?	if cause
of Vital Rec Physician: The law this certificate has ral director, page 2 : To Be Compi					10	Yes 2□No	1 Nes 2	.□ No
Of Vita Physician: this certifical director.	25. Was case referred to medical examiner?	lospitel:	Outration 20 5	Other:	ath (Check only		- (Capata)	
g Physic er this o heral dire	27. Manner of Deeth	28a. Dete of Injury 28t	Outpatient 3 C	28c. tnjury at Work?	· · · · · · · · · · · · · · · · · · ·	idence 6 Othe how injury occurre		
Attending and death. ector: Attending by the fune fune fune iffication	1 Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be	7/3/00 7:	ND PM	1☐ Yes 2√ No				
Division of Vital us or Attending Physician: The attandem!: The attandem is allorector: After this certification by the funeral director, purchification: To Be Contification: To Be Contification:	3 Suicide 6 Could not be determined	28e. Piece of Injury - At home, building, etc. (Specify)	farm street facto RESIDENCE	ry, office	BALTIMORI	(Street end Nymber wn, State) 2443	WESTPORT S	TREET,
35.29	29a. Certifier 1 ,Certifying Phys	ician: To the best of my knowled	ge, deeth occurred	d et the time, dete end plece	e, and due to the	cause(s) end mar	nner as steted.	
he Hospi in 24 hou he Funer pletely fill edical	(Check only one) 2 Medical Examination	ner: On the basis of examinetion end manner stated.	end/or investigetio	n, in my opinion, deeth occi	urred at the time	, date end place, a	nd due to the caus	e(s)
To the within 2 to the comple	29b. Signature and title of certifier	1/	29	c. License number		29d. Date aigned	(Month, Dey, Year)
	Wheel M.	le 18 ms		OCME		JULY	04, 2000	
A 2 2 2 7	30. Name and address of person who co	mpleted cause of death (Item 23)		Street, Balt	timore.	Marvland	21201	
State	31. Date filed (Month, Day, Year)	32 Registrar's Signature	4 1	Zacot, bas		- July Horied	- 140 Y	
Registrar	JUL 1 4 2000	Denue	4. 000	ula				

III The house to force

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death 3. Time of Death 2 30 Month **Physician** , 2000 Jui /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, giva street and number) Examiner HOSPICE BALTIMORE STELLA MARIS If Under 1 Yaar If Under 24 Hrs. | Months Days Hours Min. 8. Data of Birth (Month, Day, Year) MARCH 2, 1939 5. Social Security Number 7. Aga (In yrs, last birthday) Birthplace (Stata or Foreign Country) **Funeral** 247-62-378 12 M 20 F Yrs. SOUTH CAROLINA Director Usual Rasidence of Dacedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits ral', or Nema 23a or 28a-f ahow Examiner must be notified at 1 Yes 2 No Director MARILLAND ANDALLS 10e. Street and Number 10f. Zip Code 10c. Citizen of What Country? ROAL 33 MOINE USA 12. Was Decedant Evar in U,S. Armed Forcas? Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Race - American I Black, Whita, atc. 11. Marital Status lid be filed within 72 hours after de entel Hygiene. ked other than "natural", or Nem ic event, the Mrd Call Earth With 1 Yas 2 No If Yas, Giva Yaar or Datas: 1 Nevar Married 2 Married 21215-0020 1 ☐ Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced BLAC Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) College (1-4or 5+) +HGRADE JORGENSEN STEEL CO. STEEL WORKER Baltimore, Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumama) Be permit. Peges 1 and 2 should be f Department of Health end Mentel I Important: If item 27 is marked of WASH BERNICE RICHBURG KHAMES 19a. Informant's Neme/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 706 LA MOINE ROAD, RANDALISTOWN MD. 21133
Disposition (Nama of Date 20c. Location - City or Town, State important: If hem 27 any injury or other tr SANDRA RHAMES (DAUGHTER) 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition Burial 2 Crametion 3 Ramoval from Stata 7-15-00 ARBUTUS, MARYLAND 4 ☐ Donation 5 ☐ Othar (Specify) ARBUTUS CEMETERY 21. Signature of Funeral Service Lic 22. Nama and Addrass of Facility BROWN JR. FUNERAL HOME 3945 PN.H 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest,

Approximate **Physician** Immediate Ceusa (Final disaasa or condition rasulting in death) /Medical Examiner Dua to (or as a consequence of): The law requires that the death certificate be executed burial-transit Sequantially list conditions, if any, laading to immediata cause. Entar Undarlying Cause (Disaase or Injury that initieted avents rasulting in death) Last Dua to (or as a consequence of): P.O. Box 68760. Physician/Medical Dua to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Vinknown Records. Be Completed by 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 No 1 ☐ Yas 2 ☐ No Division of Vital Attanding Physician: 25. Was casa rafarred to medical 26. Place of Death (Check only ona) Site IIA MARIS AT MERLY 1 Yas 2 No Other: 4 Nursing Homa 5 Rasidence 6 Dethar (Specify) HOSDICE Hospital: Medical Certification: To 1 ☐ Inpatiant 2 ☐ ER/Outpatient 3 ☐ DOA this Mannar of Death 28a. Date of Injury (Month, Day Year) 28d. Dascribe how Injury occurred 28c. Injury at Work? 28b. Tima of After 1 Natural 2 Accident 5 Panding 1 TYes 2 □ No To the Hospital or Attandi within 24 hours after death. To the Funeral Director: A invastigation 6 Could not be datarmined 3 Suicide 281. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) filled in by 4 Homicida 19 Contriving Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signetura and titla of certifier 29c. License number 29d. Data signed (Month, Day, Year) 10,2000

Olo. 3

State Registrar DAVID

31. Deta filed (Month, Day, Year)

DHMH 16 Rev 6/95

BALTIMORE, MD

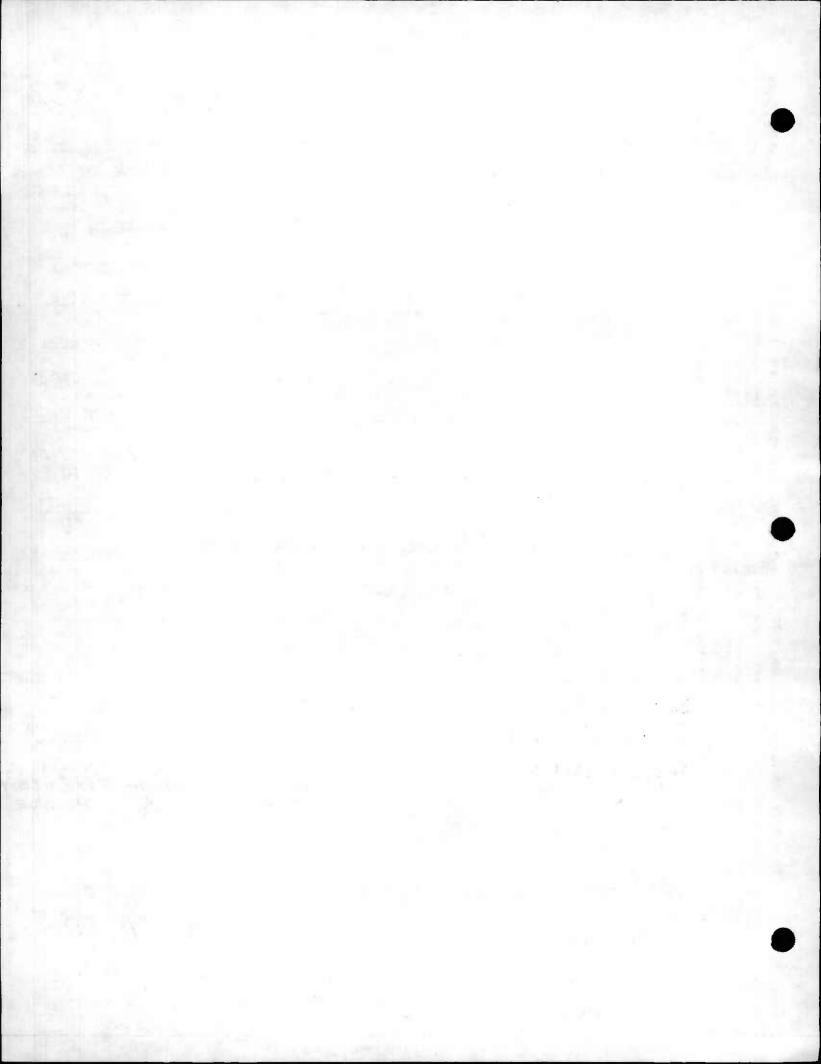
30. Nama and addrass of person who complated ceusa of death (Item 23a) (Type, Print)

2000

301

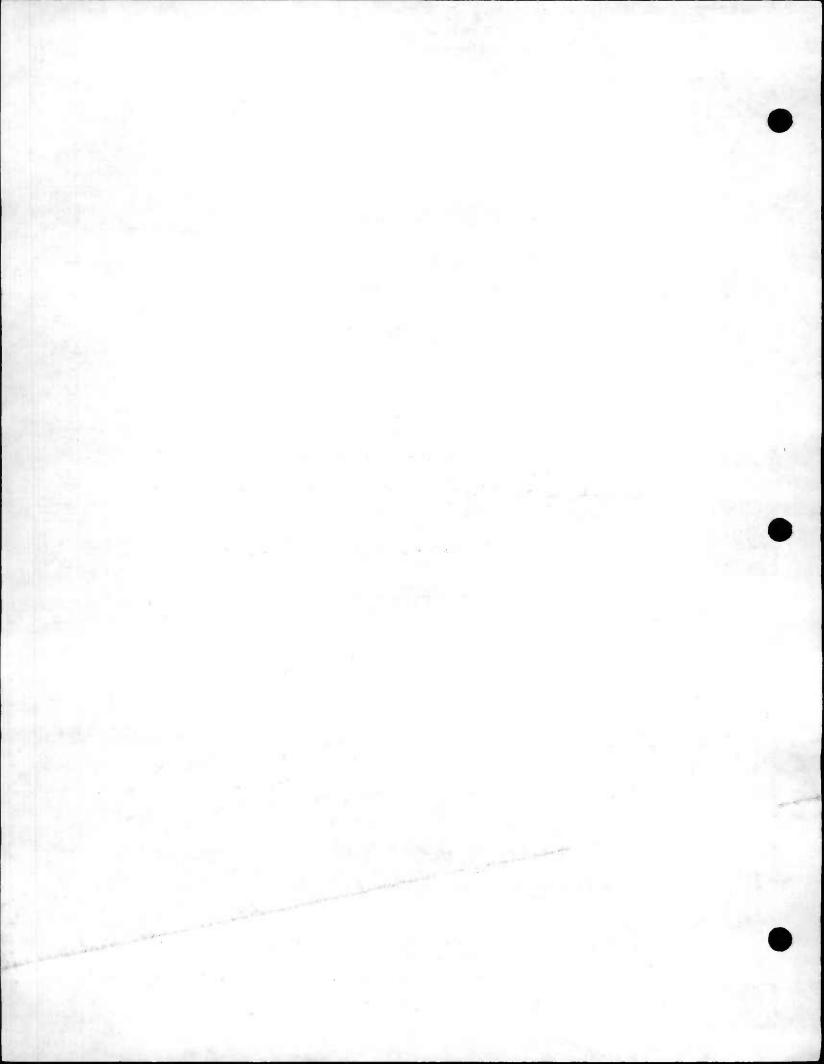
32. Registrer's Signatura

RISEBERG

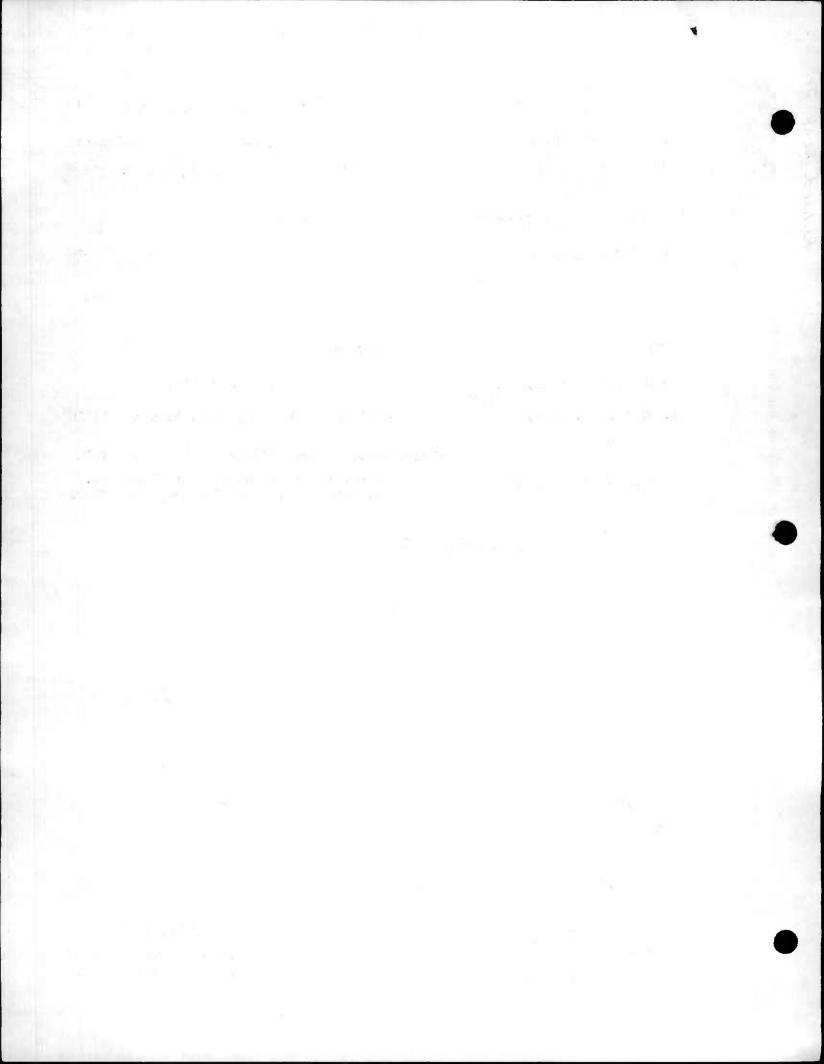


State of Maryland / Department of Health and Mental Hygiene 00 22398

					Certific	ate of	Death		Reg. No.	U 6 6	
	1. Decedent's Name	e (First, Middle, La	ist)					2. Date of De	eath		Time of Death
nysician Medical	WILLIAM	FRAN	K REA	RDON				July 6	Day 2000	Year Q	:30 PM
xaminer	4a Facility Name (fi						4b. City, Town	, or Location of Deat			.50 111
	College M	anor. In	c.				Luther	ville	Ba	ltimore	
neral	5. Social Security N	umber 6.5	Sex 7.	Age (In yrs. la:		nder 1 Year ths Days				9. Birthplace (Country)	treat of whether the control of the first terms.
ector	171-10-96 Usual Flesidence of	20	IZM 2□F	90	Yrs.	nis Days	Hous	Apr. 1		Country	MA.
be notified at Director	10a. State	10b. County		10c. City,	Town or Location		- 18				side City Limi
be notified Director	N.H.	Rocking	ham		Portsmout						□ Yes S₩N
Dir.	10e. Street and Nun	(1927)			108	Zip Code			10g. Citizen of V	What Country?	
oer must b	183 Cooli	dge Dr.				0380			USA		
iner must Funeral	11, Marital Status		12. Was Deceder Armed Force	67	13. Was De	ecedent of to specify Cub	fispanic Origin an, Mexican, P	? (Specify Yes or No Puerto Rican, etc.)	14. Rao Blac	 American Inc. White, etc. 	sian,
by	3 StWidowed	ed 2 Married 4 Divorced	1 Yes 20 If Yes, Give Year or Date:	SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEATT TO SEA	1□ Ye	s 2€ No	Specify:		Specify	Whit	e
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all du	Elementary/Secon	Control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the contro	College (1-4o	r 5+)	Ille. DO NO	T use retire	d)	177.11.00.00	NY 33 101		
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	17. Father's Name (First, Middle, Last,	,				18. Mother's	Name (First, Middle	, Maiden Sumam	0)	
fice To B	William		Reardo	n			Kathe	rine		MacCa	uley
E .	19a. Informant's Na	me/Relationship (Type, Print)		19b. Mailing Add	ress (Street	and Number o	or Rural Route Numb	er, City or Town,	State, Zip Code)
2	Mr. Edwar	d Reardon	n/son		8406 Ger	rogian	Way	Annandale	Va. 22	003	
f	20a. Method of Disp				ce of Disposition (Name of or other ola	cel	Date	20c. Location -	City or Town, S	tate
5		©Cremation 3 ☐ 5 ☐ Other (Specif	Removal from Stat	10	top Serv		3327	7/8/00	TT-	W	
를 #	21. Signature of Fur			плт	22. Nami	e and Addre	OFD.		Tows	on, Md.	
100	100	10/12	110					eral Home			
2012	- w		Dend	3				wson, Md.			
	23a. Part1. Enter It shock, or hear	t failure. List only	plications that caus one cause on each	ed the delith.	Do not enter the	mode of dyle	ng, such as ca	rdiac or respiratory a	rrest,	Inter	oximate val Between
ian										100000	it and Death
cal ner	Immediate Cause () disease or condition	Final .	· ce	uhior	Buent	21/	acc	edent		3	lays
	resulting in death)				is a consequence				1775		0
Examine		_									
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edical	If any, leading to im cause. Enter Under Cause (Disease or i that initiated events resulting in death) L			127-127-124E-1						i	
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Medical	resulting in death) L	ast [d.	but not resulti		ng cause giv	ven in Part I.	- E-11	tobacco use cor Yes 2 No		
Physician/Medical	resulting in death) L	ast [0.	but not resulti		ng cause giv	ven in Part I.	- E-11			
by Physician/Medical	resulting in death) L	cent conditions o	0.	but not resulti		ng cause gh	ven in Part I.	1 🗆 24a. Was	Yes 2□ No an autopsy	3 ☐ Probably	490 Unkno
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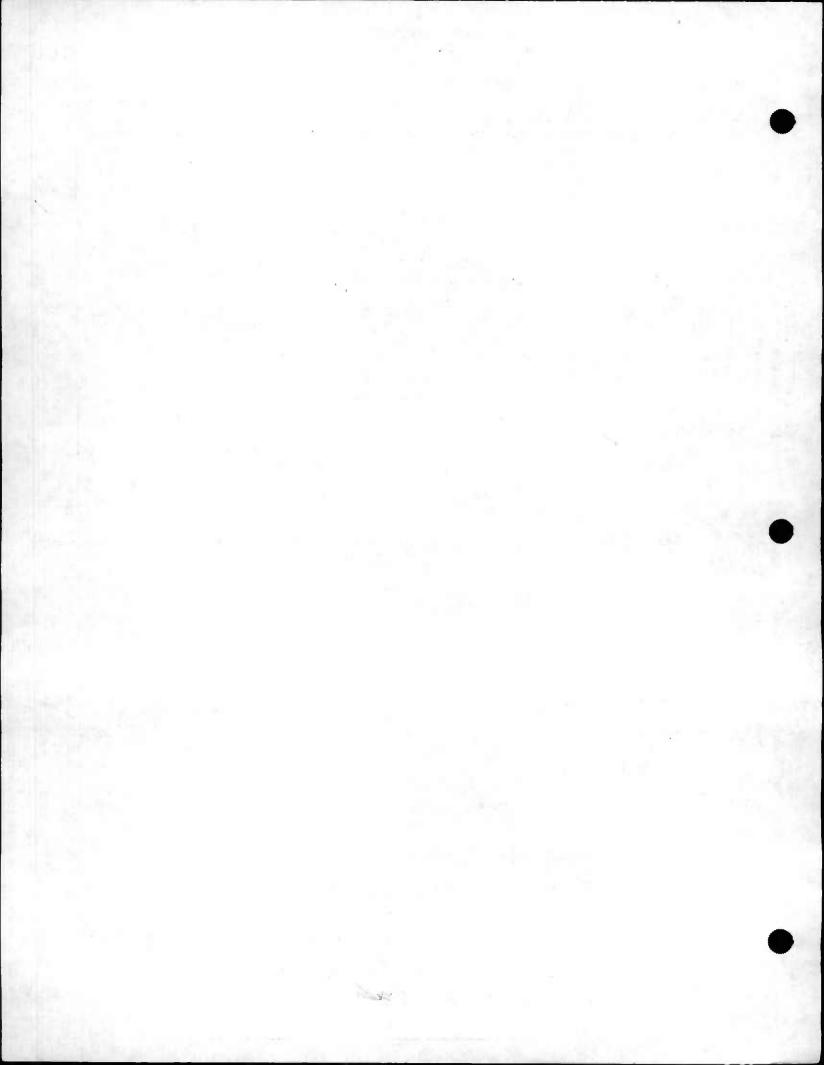
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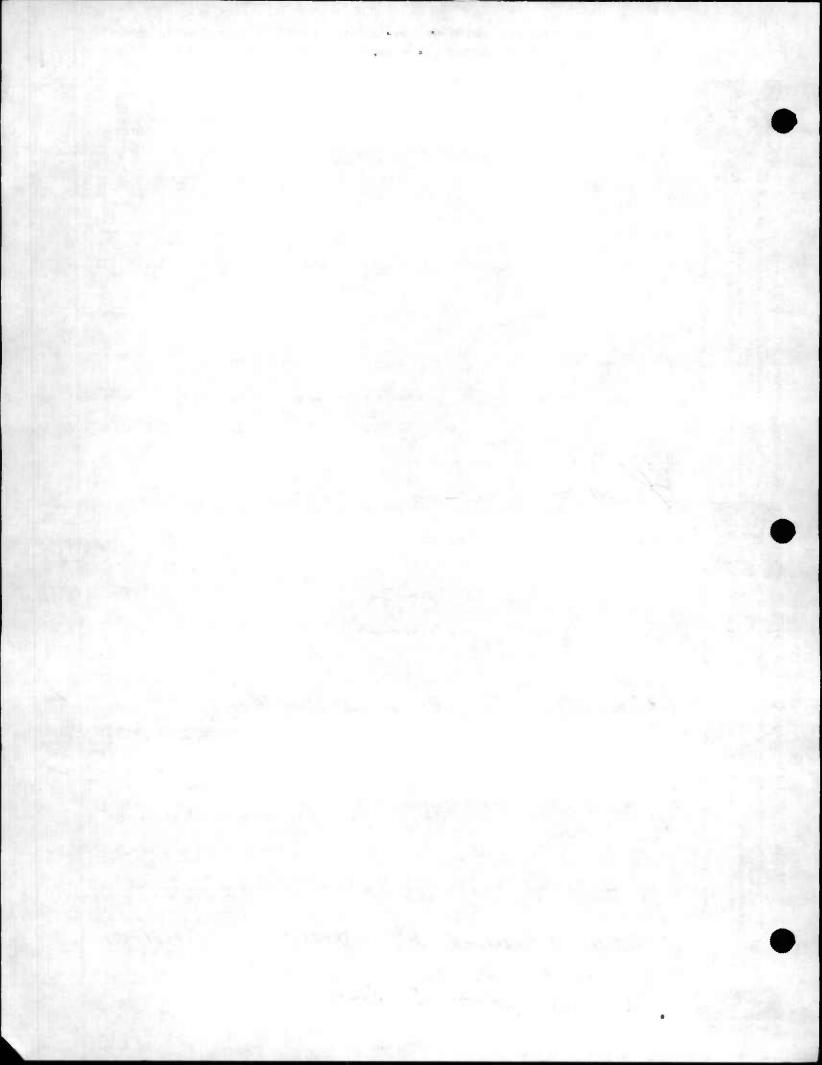
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State of Maryland / Department of Health and Mental Hygiene 00 22101

				Ce	rtificat	e of	Death			Reg. No.	00	2240
Physician (Madical	1. Decedent's Name (First, Mide Hilda Marie S								2. Date of De Month July	eath Day	000°	3. Tima of Dear 7:45am
/Medical Examiner	4a Facility Nama (If not instituti Perring Parkw						4b. City, To Parky		cation of Deat	h 4c.	County of I	
Funeral Director	5. Social Security Number 215-01-8745	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs.	83 Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bid (Month, De Mar 2	rth ay, Year) 5, 19		Birthplace (State or Fo Country) aryland
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3a or 28a-f a at be notified il Director	10e. Street and Number 3709 Bel Air	Rd.			10f. Zip 212	Code				10g. Citiz USA	zen of Wha	t Country?
natural; or items 23a or 28a-f show rideal Examiner must be notified at letted by Funeral Director	11. Marital Status 1 Never Merried 2 Ma 3 Widowed 4 Divorce	Armed F	2 ☐KNo ive	S. 13.	Wes Deced		dispanic Orlan, Mexican	gin? (Sp , Puerto	ecify Yes or No Rican, etc.)			American Indian, White, etc.
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27 is me or traums	19a. Informant's Name/Relation Patricia A. P								Al Route Numb			ite, Zip Code)
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/sician	23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complications that st only one cause on	caused the deeth	n. Do not en								Approximate Intervat Betwee Onset and Dea
Medical aminer	Immediate Cause (Finat disease or condition resulting in death)	a	CH Due to (o	r as a conse	quence of):				- A			maryya
ettending physician and for use as the bunal-transit clan/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c		r as a consec								
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'i i	30. Name and address of person	n who completed cau	ise of death (Item	23a) (Type,	Print)	20	10/10	10 ~	2/2/4			-0
Card	31. Dete filed (Month, Day, Yea.	MHIERN 32	HUKUL Registrar's Signa	tuse !	action	m	0 /1.	0	1114	9		
State Registrar		2000	grana	B	ppo	No.						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. amend item 23a,b per phys. G785 7/14/00 yg 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Year **Physician** 6:29 Am TUCY 2000 /Medical 4c. County of Deeth 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORG AGNES LJOSPITAL If Under 1 Year If Under 24 Hrs.
Months Deys Hours Min. 5. Social Security Number Birthplece (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** Deys 1□M 20 F 216-40-090 Usual Residence of Decede 58 Yrs. Director 10c. City, Town or Location 10a. Stete 10b. County 10d. inside City Limits show Nem 27 is marked other than "natural", or Nema 23a or 28a-f shor other traumatic event, the Modical Examinar must be notified at BAUTIMORE 1 Yes 2 No Director 10g. Citizen of Whet Country? 10e, Street and Number 10f. Zip Code Funeral Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuben, Mexican, Puerto Ricen, etc.) 14. Raca - American Indian, Black, White, etc. 11. Maritel Stetus Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 1 Never Merried 2 Married 1 Yes 2 No Specify à 3 Widowed 4 Divorced Completed 15. Decedent's Education city only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Indust Hygiene. College (1-4or 5+) permit. Pages 1 and 2 should be filed with Department of Haalth and Mental Hygien. Important: If Nem 27 is marked other the any Injury or other treumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Be P State, Zip Code) 20b. Placa of Disposition (Name of 20a. Method of Disposition Burlel 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licer. 23a Part. Enter the mode of dying, such as cardiac or respiratory shock, or heart failure. List only one cause on each line. Immediate Cause (Final UNKNOWN disease or condition resulting in deeth) METASTATIC LUNG CANCER Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last and Due to (or as a consequence of) physician stra bunal Physician/Medical Due to (or es e consequence of) UNKNOWN Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ

Physician /Medical Examiner

altimore, Maryland 21215-0020

P.O. Box 68760

NAME LORR NINE M Division of Vital Records,

Hospital or Attending Physician:

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To the Hospital within 24 hours a To the Funeral C

24b. Were autopsy findings evailable prior to 24a. Wes an eutopsy performed? completion of cause of deeth? 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 25 No Inpatient 2 ER/Outpatient 3D DOA 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how Injury occurred Netural 5 Pending investigation 1 Yes 2 No 2 Accident 3 ☐ Suicide

6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At home, farm, street, fectory, offica building, etc. (Specify) 4 T Homicide

29e. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, and due to the cause(s) and menner as stated. er: On the basis of exeminetion and/or investigetion, in my opinion, death occurred at the time, date end placa, and due to the ceuse(s) and manner gleted. (Check or 29b. Signature and title of certif 29d. Date signed (Month, Day, Year) 29c. License number

P19600

imiliand address of person who completed cause of death (Item 23e) (Type, Print) NASSER NASSERTASL

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32. Registrar's Signature

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BALTIMORE

July, 12, 2000

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31. Date filed (Month, Day, Year)
JUL 1 4 2000 State Registrar

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sician edical	DALLAS		577	ANLEY		JULY,	8 , 200	8:34
niner	4a Facility Nama (If not institution, s	SPITAL	•	ER	**	Location of Death		
al or	5. Social Security Number 6 231-32-9759		ge (In yrs. last birtl			(Month, Day		Birthplaca (State or Foreign Country) VIRGINIA
	Usuat Residenca of Decedent 10a. Stete 10b. County	W BIT	10c. City, Town	or Location	1007			10d. Inside City Limits
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ai Directo	10e. Street and Number 103 DENSON DRIVE			10f. Zip Code	21144		10g. Citizen of W	
by Funeral	11. Marital Status 1 □ Naver Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Deceden Armed Forces XXYas 2 ☐ If Yes, Give Year or Detes	No 1947-	13. Was Decedent of If Yas, specify Cu		Specify Yes or No- to Rican, etc.)		- American Indian, k, White, etc. WHITE
Completed	15. Decedent's (Specity only highest of Elementary/Secondary (0-12)	Education rade completed) College (1-4or	5+)	Decedent's Usual Occi (Give kind of work don life. DO NOT use retir AFF SERGEA)	ed) during most of wo	rking	16b. Kind of But	
	12 17. Father's Name (First, Middle, La.	s()	21.	AFF SERGEAL	7	me (First, Middle,		
To Be	JAMES		ANLEY		FRANCES	, , , , , , , , , , , , , , , , , , , ,	FLEM	Mark .
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	Bing. Cly		138					, MARYLAND210
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by Physician/		ARTERY				16		3 Probably 4 Unknow
Completed			11-41				an autopsy med?	24b. Were autopsy findings available prior to completion of causa of death?
mo						1 D Y	es 20 No	1 ☐ Yes 2 ☐ No
Be	25. Was case referred to medical examiner?					eth (Check only o	ne)	
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edical			of examination and		opinion, death occ	urred at the time, o	dete and placa, e	and due to the cause(s)
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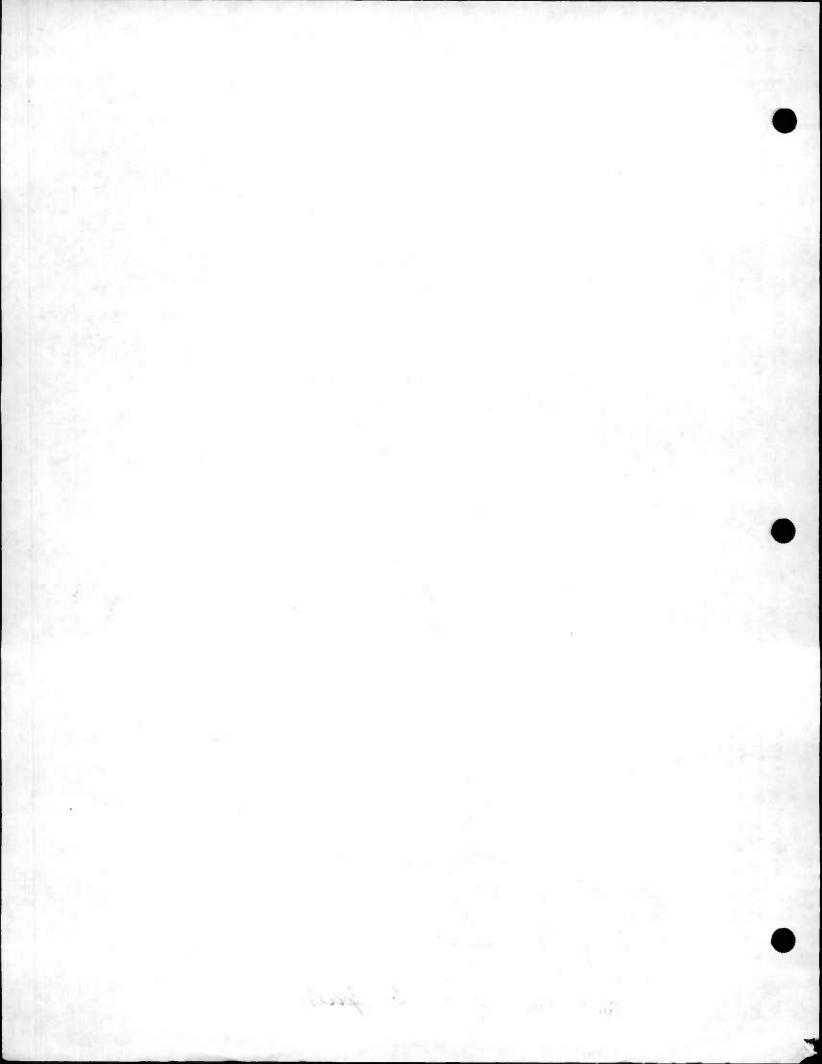
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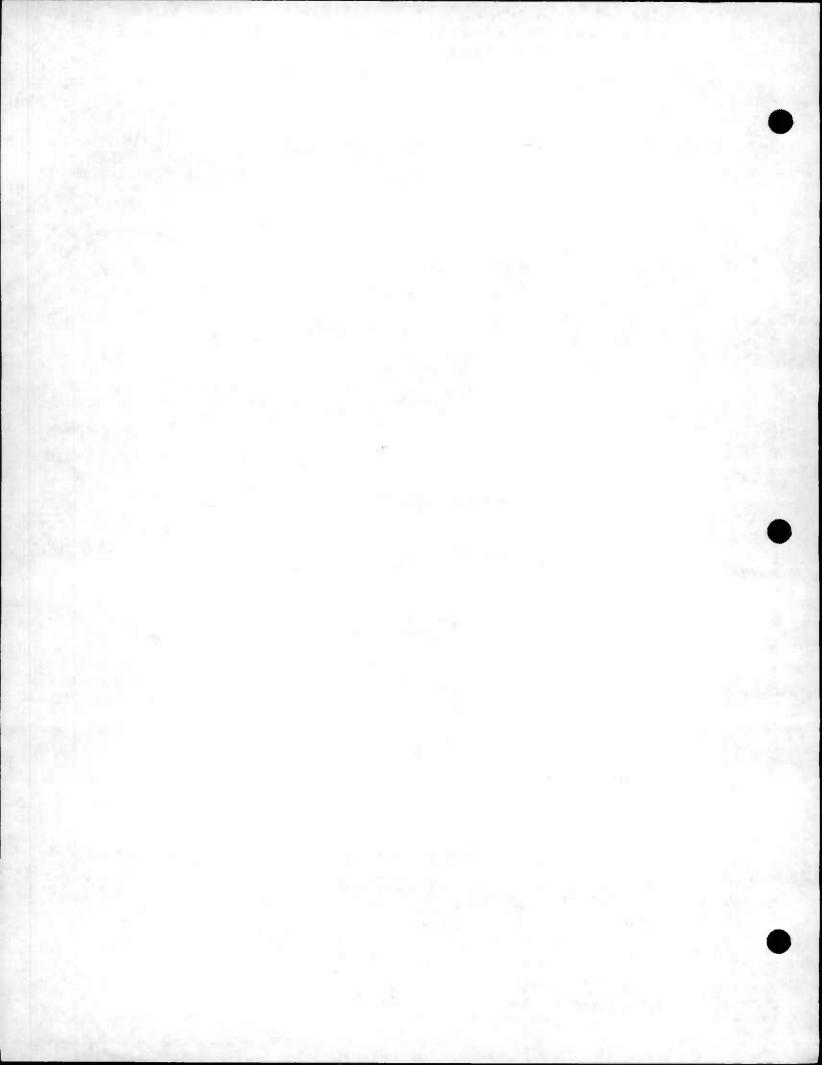
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aminer	4a Fac	llity Name (If not institution		reet and nu	ımber)				4	b. City, To	wn, or Lo	ocation of De	ath 4	lc. County	of Death	
		POPLAR ROA								MILLE					ARUNI	
eral ctor	40	al Security Number 7-22-2774	6. Sex 1□	M 2₩ F	7. Age (In	yrs. last birt	rs.	If Under Months	Deys	If Under Hours	Min.	8. Date of (Month, OCT.	Birth Day, Yea 7, 1	926	9. Birthpi Coun KENTI	ece (State or Forei iry) JCKY
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or other traumatic event, ma Ma	Elem	entary/Secondary (0-12)		College	(1-4or 5+)								77	5 (וחשער	IMENIO
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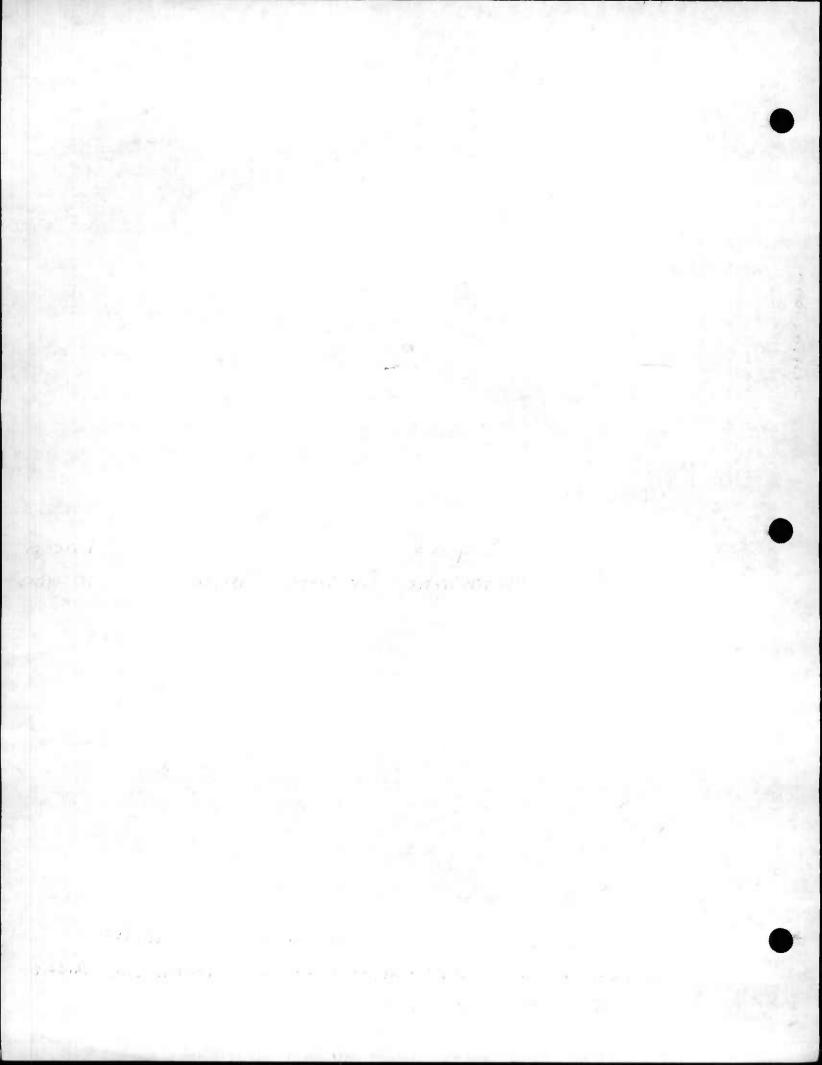


State of Maryland / Department of Health and Mental Hygiene 22406 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** July 9, John Francis Sheska 2000 12:00 am /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Genesis Eldercare Franklin Woods Baltimore County Baltimore If Under 1 Yaar | If Undar 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthdey) **Funeral** 1 M 2 □ F Yrs. 002 09 1653 83 March 2, 1917 Director New Hampshire Usual Residence of Decedent 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Maryland Baltimore Baltimore County Directo 288-1 10e. Street and Number 10g. Citizen of What Country? 10f. Zin Code 23s or 9467 Seven Courts Drive 21236 USA Funeral Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Mexican, Puarto Rican, atc.) 14. Race - American Indian, Black, White, etc. or Mems 12. Was Decedent Ever in U,S. Armed Forcas? 11. Marital Status 1 Nevar Married 2 Married □Yes 2 □ No Yes, Give Saltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify. White Specify: 3 √Widowed 4 Divorced Yaar or Dates: WW II Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) T.V. Repairman Self Employed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Be permit. Pages 1 and 2 should be 1 Department of Health and Mental Important: If New 27 Is merked of Stanley Sheska Helen Butkiewicz 19a. Informent's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Frances Ruth Hubard (Niece) 116 Glider Drive Baltimore, Maryland 21220 20b. Place of Disposition (Name of cemetery, crematory or other placa) 20e. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State St Joseph Church Cem. July 11, 2000 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name end Address of Facility Lassahn Funeral Home, Inc. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heart feiture. List only one cause on each line. 7401 Belair Road Baltimore, Maryland 21236 Approximate Interval Between Onset and Death **Physician** riviedicar Immediate Cause (Finel disease or condition resulting in death) week Examiner Due to (or as a consequence of) Concer Physician/Medical Examiner The lew requires that the deeth certificata be executed attending physicien and for use es the burial-trans Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events rasulting in death) Last Due to (or as a consequence of P.O. Box 68760. Due to (or as a consequence of): Part It. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 | Yes 2 | No 3 | Probably 4 | Unknown Division of Vital Records. edical Certification: To Be Completed by 24b. Were autopsy findings available prior to completion of ceuse ot death? 24a. Was an autopsy performed? pege 2 should certificate has 20 No 1 Yas 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: funeral director, 25. Was cese referred to medicel examiner? 26. Place of Death (Check only one) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 3 DOA After this 28a. Date of Injury (Month, Dey Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Netural 5 Panding investigation I after deeth.
I Director: Af ed in by the fu 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicida Location (Street and Number or Rural Route Number, City or Town, Steta) 28e. Place of Injury - At home, tarm, streat, factory, office building, etc. (Specify) completely filled in by 4 ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and plece, end due to the ceuse(s) and manner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred et the time, date and place, and due to the cause(s) and mannar stated. 29a. Certifier To the I 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2/10/00 D53462 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Glen Burnie, mD 21061 Road 7845 OBHWOOD Munases Jude 31. Data filed (Month, Day, Year) 32. Registrar's Signature State JUL 14 2000 Registrar

DHMH 16 Rev 6/95

SHESKIA, JOHN



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene | | Certificate of Death 2. Date of Death 3. Time of Death 1. Decedant's Nama (First, Middle, Last) Day Month Yaar **Physician** Tewa 1aene 11:20 AM 2000 JUL 6 /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) Examiner emo 10 more If Under 24 Hrs. 8. Date of Birth A Month, Day, If Under 1 Year 5. Social Security Number 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Months Hours 218-07-2391 Usual Residence of Decedent 1⊠M 2□F Ma Director 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits ahous Itam 27 is marked other than "natural", or itams 23s or 28s-f aho other traumatic avant, the Medical Examinar must be notified as 1 Yes 2 No Director Maryland 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral Lla Ve 12. Was Decedent Ever in U,S.
Amed Forces?

1 ∀es 2 □ No
I/Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Ricen, etc.) 14. Race - Americen Indian Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours after 1 Nevar Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify by Specify: 3 ₩ Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Il Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) ohn 18. Mothar's Name (First, Middle, Maiden Surname) 17. Fathar's Nama (First, Middla, Last) permit. Peges 1 end 2 should be Department of Health and Mental Important: If Itam 27 is marked or any injury or other traumatic avs 0 mma ၉ War mber, City or Town, State, Zip Code (sister) 19b. Mailing Address (Street and Number or Rural Route Number, 19a. Informant's Name/Relationship (Type, Print) 302 evenson 20b. Place of Disposition (Name of cemetery, crematory or other place) /Date 20c. Location - City or Town, State 20a. Method of Disposition 7/14/2000 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) reenmount remator 21. Signature of Funeral Service Licenses 22. Nama and Address of Facility Joseph 2222 V SS Luneral Hom W. North Balto. Md. Ave. in the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, Approximata Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final PNEUMONIA ASPIRATION disease or condition resulting in death) DAYS Examiner Due to (or as a consequence ot) Examiner The law requires that the death certificate be executed the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and Box 68760. Physician/Medical Due to (or as a consequenca ot) detached for use es Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? Records, P.O. signed by I 1 No 2 No 3 Probably 4 Unknown CHRONIC OBSTRUCTIVE PULMONIARY Completed by 24b. Were autopsy tindings available prior to 24a. Was an autopsy performed? CHRONIC VENOUS STASIS completion of ceuse of death? 1 Yes 2 No 1 Yes 2 No BERMATI TIS TO BILATERAL LOWER EXTREMITIES of Vital Physician: 25. Was case reterred to medicel examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) Juneral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Division 1 Naturai or Attending 5 Pending investigation 1 Yes 2 No r deeth. 2 Accident 24 hours after deel Funeral Director: 6 Could not be 3 Suicida 28t. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, tarm, straat, factory, office building, etc. (Specify) filled in by 4 D Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. edical To the Hosp within 24 hor To the Fune completely fi 2 Medical Examiner: On the besis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifian of mother AT2438946 mo JUN 6, 2000 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

State Registrar

DHMH 16 Rev 6/95

UNION MEMORIAL HOSPITAL, BANTIMORE, MD

, MD

32. Registrar's Signature

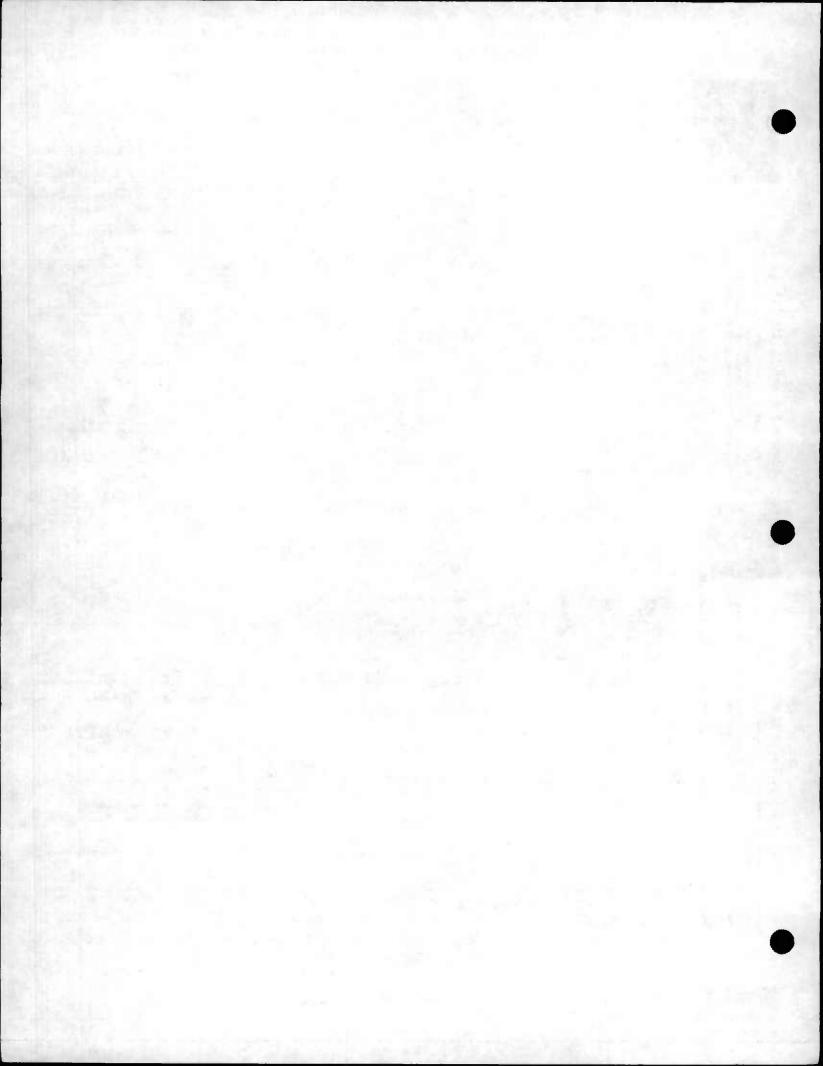
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JENNIFER 31. Date tiled (Month, Day, Year)



State of Maryland / Department of Health and Mental Hygiene

22408 Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death 3. Time of Death July 11, 2000 **Physician** Robert B. Tipton 9:45 a.m. /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Center for Hospice Towson Baltimore If Undar 1 Yaer | If Undar 24 Hrs. 8. Data of Birth (Month, Day, Year) 9. Birthplaca (Stata or Country) March 19, 1938 Tennessee 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foraign Country) **Funeral** Days IXXXM 2□ F Months Hours 413-56-5386 62 Director **Usual Residence of Decedent** 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits "naturel", or items 23s or 28s-f show 1 ☐ Yes 2 NO Maryland Baltimore Middle River 10a. Street and Number 10f. Zip Code 10g. Citizen of What Country? id 1811 Wlison Point Road 21220 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-ff Yas, specify Cuban, Maxican, Puarto Rican, atc.) 14. Rece - American Indien, 12. Was Decedent Evar in U,S. Armed Forces? Black, Whita, atc. 1 Yas 2 No If Yas, Giva Yaer or Datas: 1 Nevar Married 2 Married 1 Yes 20 No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grada completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Builder-Owner Construction 17. Father's Name (First, Middla, Last) 18. Mother's Name (First, Middla, Maidan Sumame) Be 2 should be f le marked William Tipton Myrtle Moore 2 19e. Informent's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Pages 1 and 2 s Important: If Item 27 I Hazel Tipton (wife) 1811 WilsonPoint Road, Baltimore, Maryland 21220 20b. Place of Disposition (Nama of cematary, cramatory or other place) 20e. Mathod of Disposition Date 20c. Location - City or Town, Stata 1 Burial 2 □ Cramation 3 □ Removal from Stete 4 ☐ Donation 5 ☐ Othar (Specify) Holly Hill Mem. Gardens 7/14/2000 Baltimore, Maryland 21. Signature of Funeral Septem Licensee 22. Name end Addrass of Fecility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1. First the disease, or complications that caused the death. Do not anter the mode of dying, such as cardiac or respiretory errest, show the failure. List only one cause on each line. Approximata Intarval Between Onset and Death **Physician** CANCER /Medical Immediate Cause (Final wars disease or condition resulting in death) Examiner Examiner Sequentially list conditions, if any, laading to immadiata causa. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Dua to (or es e consequença of): physician at the bunal Physician/Medical Dua to (or as a consequence of): 980 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b, Dfd tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Ware autopsy findings available prior to complation of causa of death? 24a. Was an autopsy performed? Completed The law 1 Yas 2 No 1 Yes 2 No 25. Was casa rafarred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yas 2 No Dice To HOS his 27. Mannar of Death 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? Medical Certification: or Attending Natural 5 Pending investigation death. 1 Yas 2 No 2 ☐ Accident Director: / 6 Could not be 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 ☐ Suicide 28e. Plece of Injury - At homa, farm, straet, factory, office building, atc. (Specify) after 4 Homicide To the Hospital o within 24 hours aff To the Funerel Di Completely filled in 1 Certifying Physician: To the best of my knowledge, daath occurred at tha tima, data and placa, and dua to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of axamination and/or invastigation, in my opinion, death occurred at the tima, date and placa, and dua to the causa(s) and mannar stated. 29a. Certifier 29c. Licansa number 29d. Date signed (Month, Day, Year) 29b. Signature and tale of cartifie 2000 and 23a) (Type, Print) N. Charles S. Balto Md 21204 A 6201 32. Registrat's Signatura State

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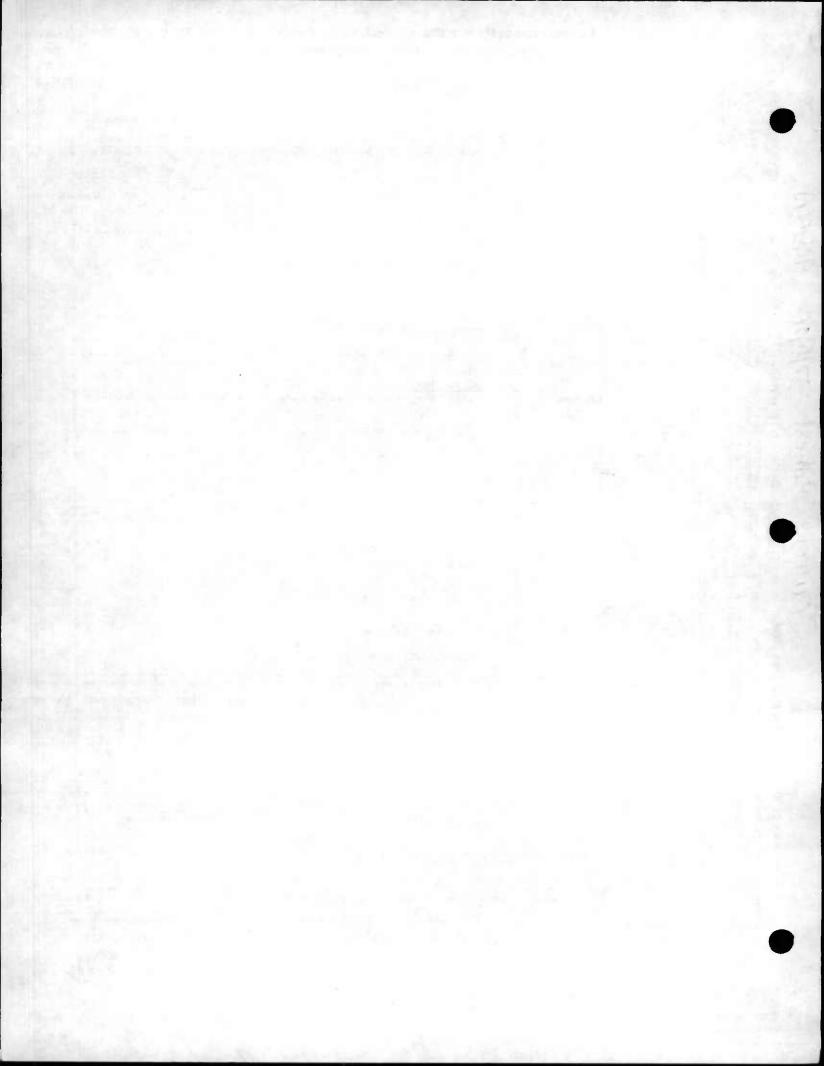
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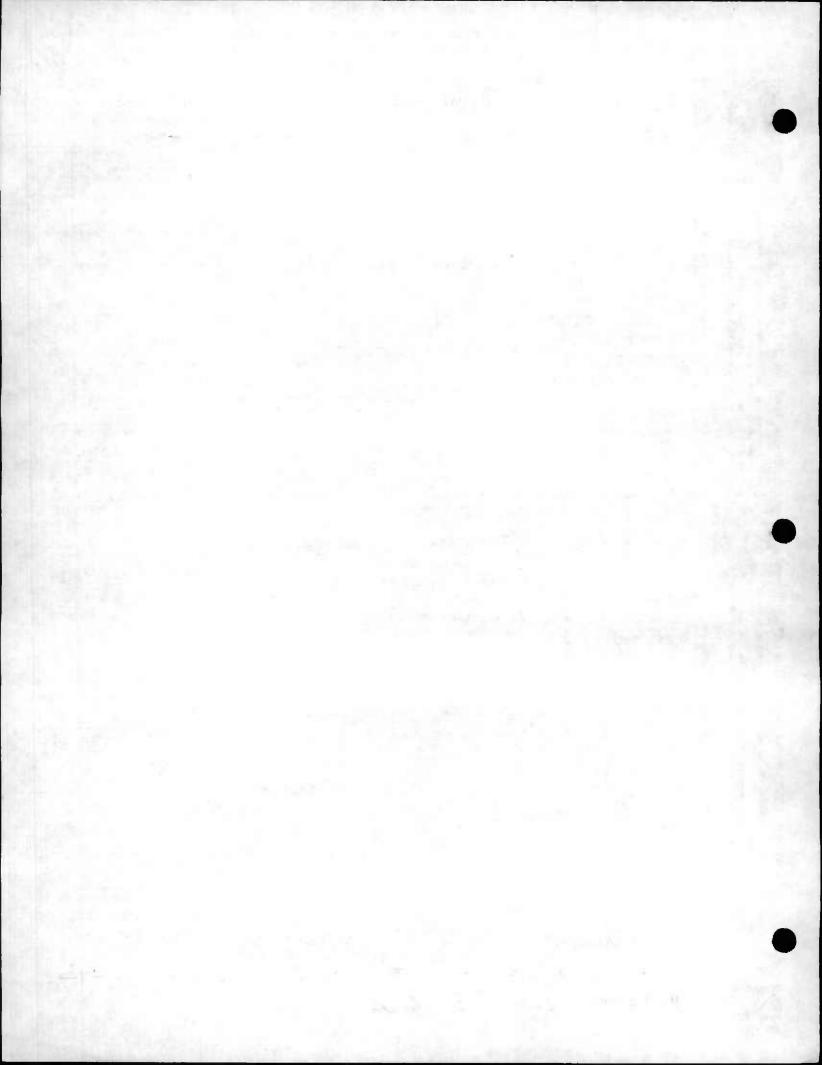
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State of Maryland / Department of Health and Mental Hygiene

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Tima of Death Day **Physician** 10 8:08 a.m. 2000 Mae Bradley Truesdale /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore Future Care Canton Harbor If Under 1 Year | If Under 24 Hrs. 8. Data of Birth (Month, Days Hours Min. 1-13-1922 5. Social Security Number Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** 10M 2XTE Months 78 Yrs. Va Director 212-22-0727 Usuat Residence of Decedent 10e State 10h County 10c. City. Town or Location 10d. Inside City Limits ns 23a or 23a-f shor must be notified at YYas 2 No Director Md N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21213 USA 2624 Brendan Avenue Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Specify:Black Baltimore, Maryland 21215-0020 1 Yes XXNo Specify: à permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hyghene. Important: If them 27 is marked other than "natural", any injury or other traumatic event, the Medical Examptide. 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Private Homes Domestic UNK WKK 18. Mother's Name (First, Middle, Maiden Surnama) 17. Father's Nama (First, Middle, Last) Be Loverne Rucker James H. Hunt 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Baltimore, Md 21213 Dwight Smith - Stepson 2624 Brendan Avenue 20b. Place of Disposition (Nama of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata XX Burial 2 Cremation 3 Removal from State 7-14-00 Baltimore, Md 4 ☐ Donation 5 ☐ Other (Specify) Loudon Park Cemetery 22. Name and Address of Facility
March F/H West ture of Funeral Service Lid 4300 Wabash Avenue Baltimore, Md 21215 23a. Plat. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediata Cause (Final disease or condition resulting in death) /Medical Panerson? (oncer Examiner Due to (or as a consequence of) Physician/Medical Examiner The law requires that the death certificate be asscuted attending physician and for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Due to (or as a consequence of) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Den ETA 1 Yes 2 No 3 Probably 4 Unknown signed b þ 24b. Were autopsy tindings available prior to completion of cause of death? Arterio Silvoti VAScular Dism Be Completed 24a. Was an autopsy 1 | Yes 2 000 1 □ Yas 2 □ No certificate Division of Vital al or Attending Physician: To safter death. Il Director: After this certificate ed in by the funeral director, pa 25. Was case referred to medical 26. Place of Death (Check only one) axaminer? Other Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 topatient 2 EP/Outpatient 3 DOA edical Certification: To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of Injury - At homa, tarm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 D Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Data signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 0 24276 2

DHMH 16 Rev 6/95

State

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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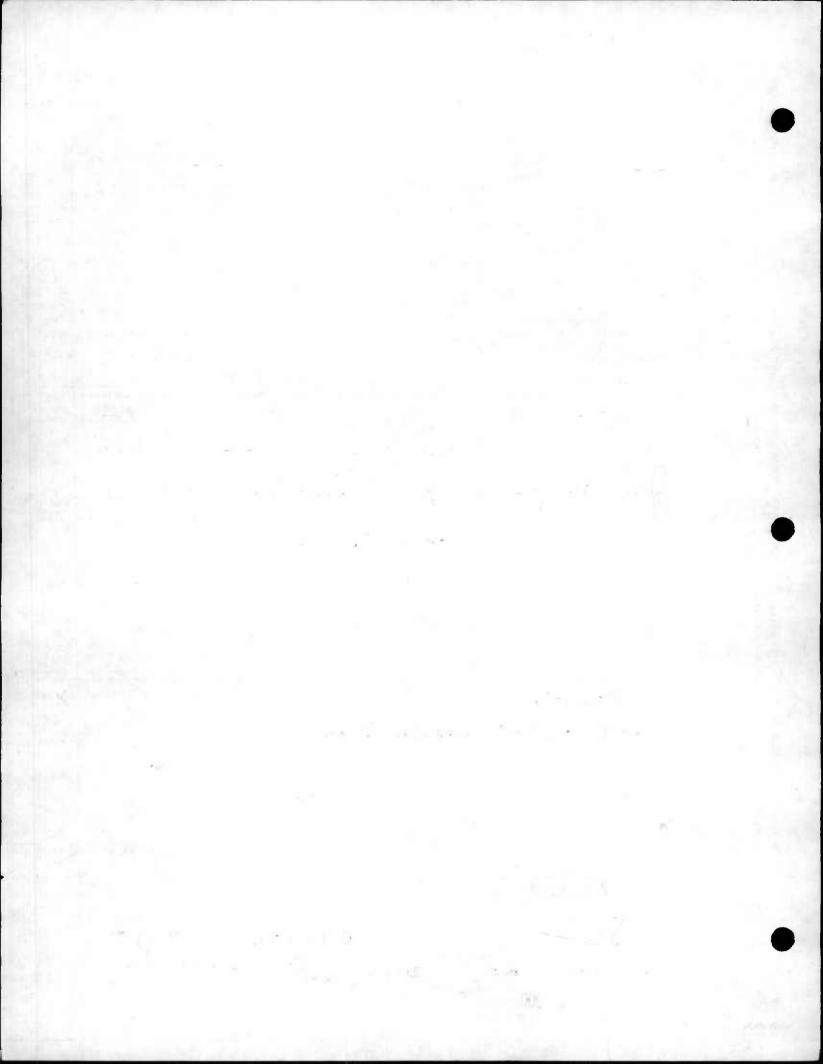
32. Registrar's Signature

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31. Data filed (Month, Day, Year)



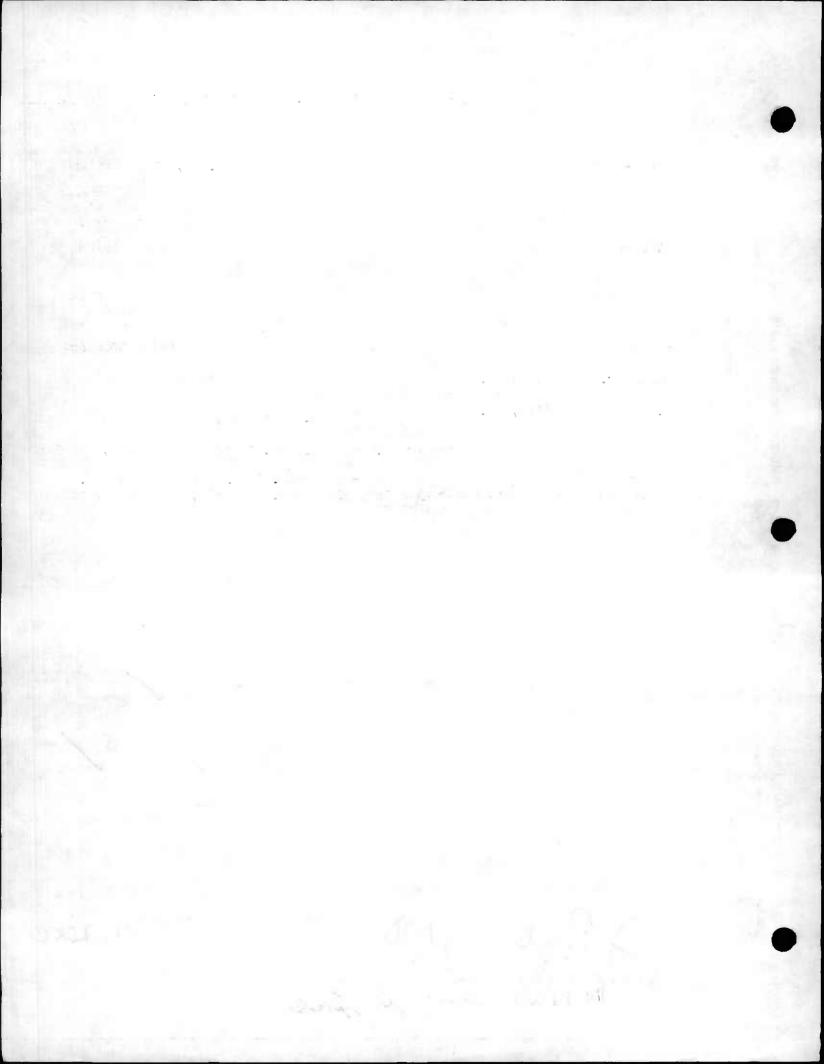
Please Type or Print in Black Indelibie ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death 1040 ANI **Physician** 2000)U /Medical 4c./County of Death 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) Examiner OSDIC If Under 24 Hrs. If Under 1 Yaar 8. Date of Birth (Month, Day, Birthplace (S(ate or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1918 Days 230-26-1918 Usual Residence of Decedent 1 M 2 F Yes. Director 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Directo Virginia 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1W000 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Yas 2 No If Yas, Giva Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 ☐ Married 1 ☐ Yes 2 No Specify: Specify: Bla 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1a Pages 1 and 2 should be filed sent of Health and Mental Hygi int: If them 27 is marked other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be aVI repartment of Health and Important: If Item 27 is m. any injury or 19a. Informant's Name/Ralationship (Type, Print) (daughter) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2010. Place of Disposition (Nama of cometery, crematory or other place)
Little Mine Rd. Bapt. Ch Shington, Md, 20744 Baltimore, 20a. Method of Disposition Date, 1 Burial 2 Cremation 3 Removal from State 2000 Spotsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Toseph L. R.1 21. Signature of Funeral Service License Joseph 2222 V 5 tuneral Ave. WiNorth Balto. 23a. Part I enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, sheet, or heart failure. List only one cause on each line. Approximate Interval Batween Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Lung cancer Examiner Due (or as a consequence of) -IVER metastases attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? Alzheinen's disease been signed a by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of cause of death? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examinar? 26. Place of Death (Check only ona) Richey 1□ Yes 25 No Other: 4 Nursing Home 5 Residence 6 Rother (Specify) Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this 28a. Data of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Mannar of Death 28c. Injury at Work? 28b. Time of 1 Natural 5 Pending investigation ne Hospital or Attendin n 24 hours effer death. The Funerel Director: Aftipletely filled in by the fun 1 Yes 2 No 2 Accident 6 Could not be detarmined . Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide 29a. Certifier Certifying Physician: To the best of my knowledga, death occurred at tha tima, data and place, and dua to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tima, data and place, and dua to the cause(s) and manner stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ec 30. Name and address of person who completed causa of death (Item 23a) (Type, Print) Baltimore 21201 Powell 54: Reac homas 101 32. Registrar's Signature State 2000 Registrar DHMH 16 Rev 6/95

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ral tor	5. Social Security P		6. Sex 12□ M 2□ F	7. Aga (In 29	n yrs. last birl	thday) If Und Months	er 1 Year Days		in. 8. Data of B (Month, L Sept.	irth Pay, Year) 13,1970	9. Birth Cou Mar	placa <i>(Stata or Foreign</i> nin) 'Yland
	Usual Residence of 10s. State	Decedent 10b. County		10	C. City, Town	or Location						10d. Inside City Limits
rector	Maryland	Ва	altimore					Edgemere	9			1 ☐ Yas 2 ☒ No
Director	10e. Street and Nu	mber				10f. Z	ip Code			10g. Citizen of	What Cou	nfry?
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Certification:	3 ☐ Suicide 4 ☐ Homicide	6 ☐ Could n determin	ot be ned 28e. Plac buik	ce of Injury - ding, etc. (S	At home, fer Specify) PI	m, street, facto	ory, office		28f. Location City or T BALTO.,	(Street and Num own, Stata)771 MD	ber or Run 3 IROQ	ul Routa Number, UOIS RD.
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Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth 3 Time of Death Dev Month Year Physician Sandra Gertrude Watkins 0600 Am Julu 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Deeth 4a Facility Name (If not Institution, give street end number) **Examiner** Hopkins Baltimore 7. Age (In yrs. last birthdey) City Johns If Under 1 Year If Under 24 Hrs. 8. Dete of Birth (Months Deys Hours Min. 1-9-1949 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 20 F 51 220-54-7234 Yrs Director Md Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits a or 28a-f show 10a. Stete Md N/A Baltimore 1 ☐ Yes 2 ☐ No Director 10e. Street end Number 10f. Zip Code 10g. Citizen of Whet Country? USA ma 23a 320 S. Herring Court 21231 Funeral death 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after c Department of the bith and Mental Hygiene. Important: If them 27 is marked other than "natural", or then any Injury or other traumatic event, the Medical Exercises. 14 Never Merried 2 Merried 1 Yes 2XXVIII
If Yes, Give
Yeer or Detes: Specify: Black 1 ☐ Yes 2X No Specify: by 3 Widowed 4 Divorced Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) Hote1 10th grade Custodian 18. Mother's Neme (First, Middle, Maiden Surneme) 17. Father's Neme (First, Middle, Last) Be Alfred E. Smith Naomi Watkins OL 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) Andrea Elliott - Sister 6810 Park Heights Apt 309 Baltimore, Md 20e. Method of Disposition 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete Dete 1 D Buriel 2 DCremetion 3 □ Removal from State Metro Crematory 7-17-00 Catonsville, Md 4 ☐ Donetion 5 ☐ Other (Specify) 22. Neme end Address of Fecility of Funerel Service Licenses March F/H West 4300 Wabash Avenue Baltimore, Md 21215 Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Physician /Medical Immediete Cause (Finel artery O years · Coronary disease or condition resulting in deeth) disevac Examiner Due to (or es e consequence of): Examiner The law requires that the death certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Diseese or Injury that initiated events resulting in deeth) Lest Due to (or es e consequence of): physician a Physician/Medical Due to (or es e consequence of): usa signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown þ 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Wes en eutopsy performed? Completed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ₺ No Physician: 25. Was case referred to medical exeminer? Be 26. Place of Deeth (Check only one) To Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Dete of Injury (Month, Dey Year) funeral 27. Menner of Deeth 28b. Time of Certification: 28c. Injury et Work? 28d. Describe how injury occurred or Attending 1 Neturel 5 Pending Investigation 1 Yes 2 No death. To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the f 2 Accident 6 ☐ Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end place, end due to the ceuse(s) end menner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and menner stated. edical 29a. Certifier (Check only one) 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signature end title of certifier

State Registrar

Jason

M.D. , Johns Hopkins 31. Dete filed (Month, Dev. Year) 32. Registrer's Signeture JUL 1 4 2000 oaks

30. Neme and address of person who completed cause of deeth (Item 23e) (Type, Print)

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Keith

Sicklick

21215-0020

Baltimore, Maryland

Box 68760,

Records, P.O.

of Vital

Division

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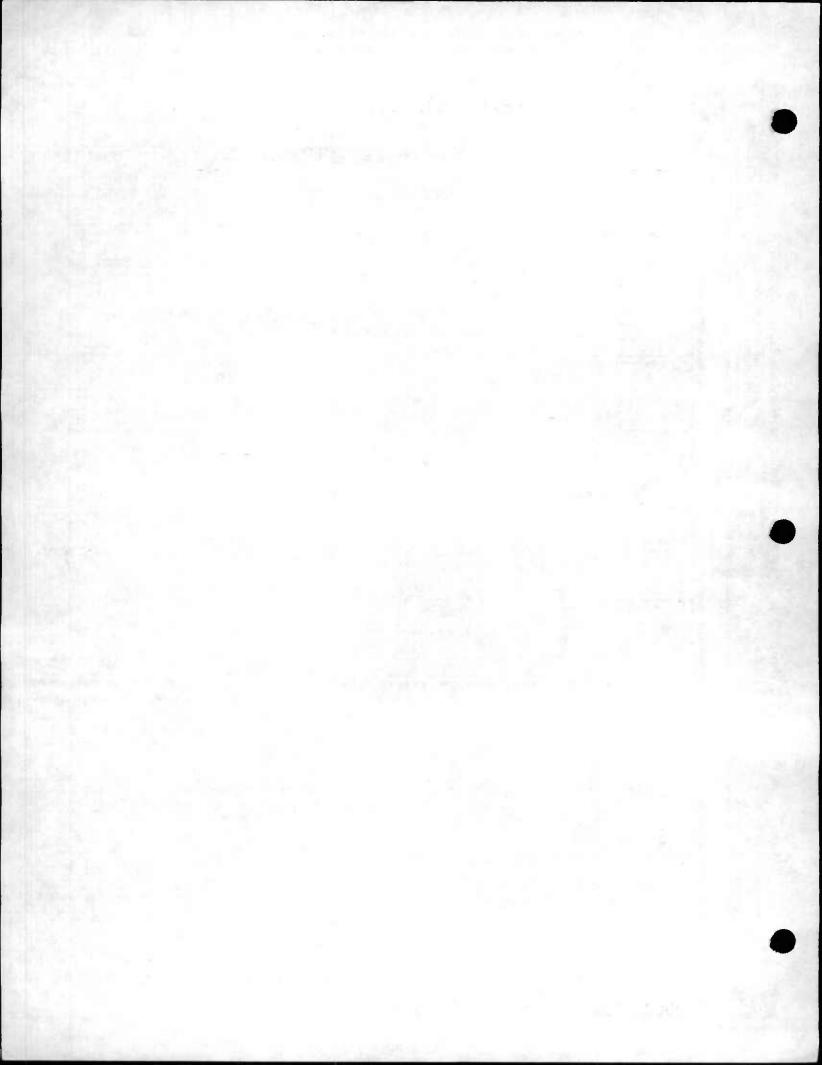
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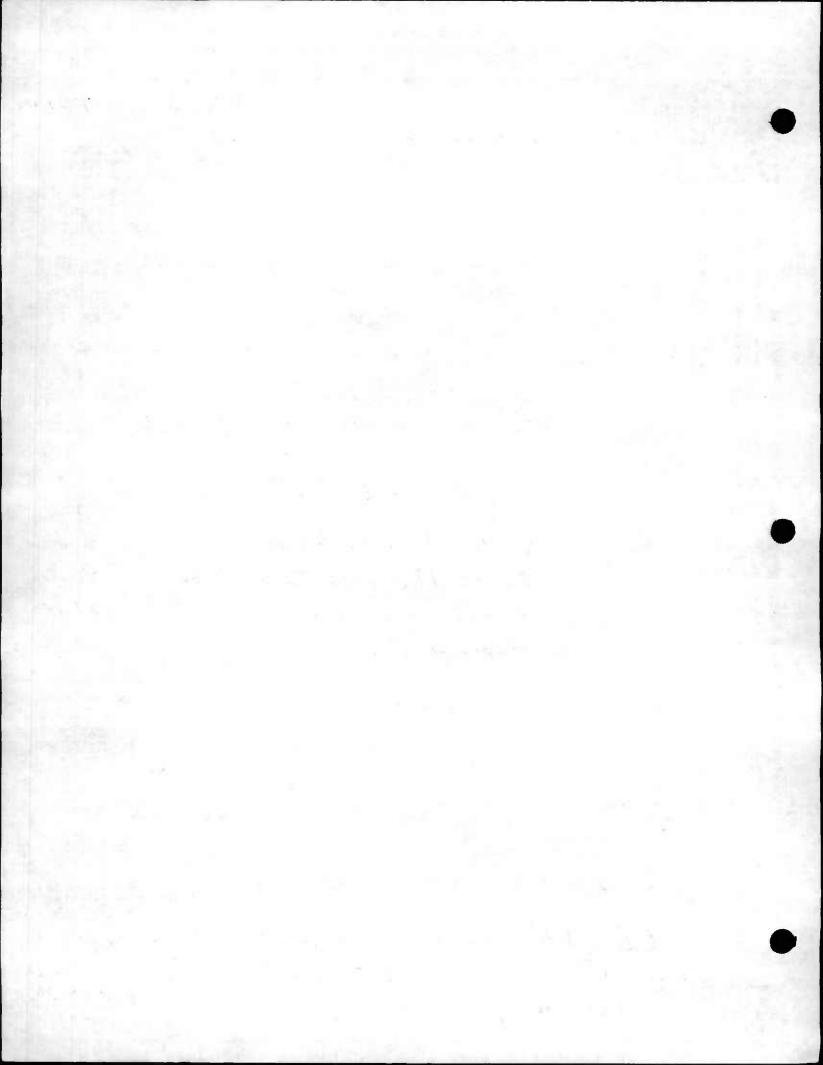
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Hospital, 600 North Walfe Street, Blalock 655

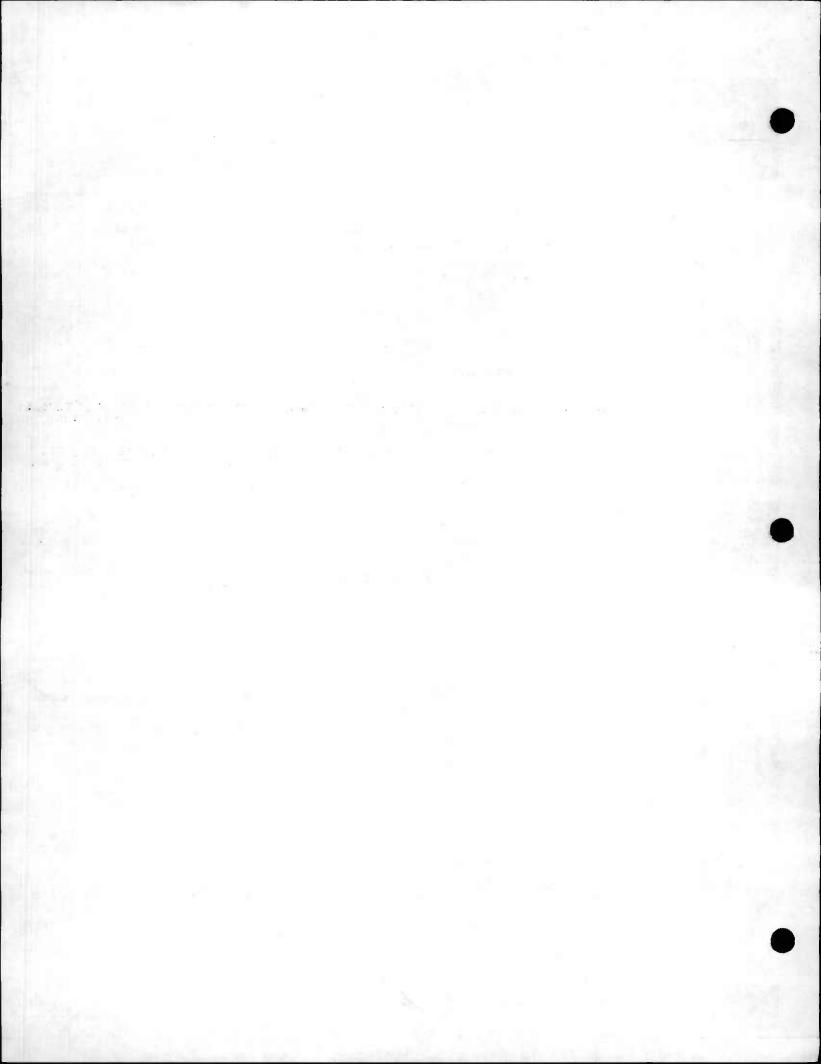


State of Maryland / Department of Health and Mental Hygiene amend item 16b per fh G785 7/14/00 yg Certificate of Death 1. Decedant's Nama (First, Middla, Last) 2. Data of Death 3. Tima of Death July Year **Physician** 9:51AM Watson Fred Μ. 2000 /Medical 4b. City, Town, or Location of Daath 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Examiner Samaritan Hospidal Boltimore If Under 1 Year If Undar 24 Hrs. 7. Aga (In yrs. last birthday) 6. Data of Birth (Month, Day, Year) Birthplaca (Steta or Foreign Country) **Funeral** Days Months Hours XXM 2DF 78 Director 243-14-3651 Usuet Residence of Deceden with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 1 Yas 2 □ No Director Baltimore 10e. Street and Number 10f. Zin Coda 10g. Citizen of What Country? 238 Funeral 21239 U.S.A. 2018 Northbourne Road 14. Race - Amarican Indian, Black, Whita, atc. 12. Was Decedent Ever In U,S. Armad Forcas? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxicen, Puarto Rican, atc.) 11. Maritat Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "naturel", or the eny injury or other treumatic event, the Medical Examina 1 X Yas 2 ☐ No If Yes, Give Yaar or Datas: 1 Navar Married 2 Married 1 Yas 2 No Specify. Specify: ۵ 3 N Widowed 4 □ Divorced Black Completed 15. Decedent's Education (Specify only highast grada complated) 16a. Decedant's Usuel Occupetion (Giva kind of work dona during most of working life. DO NOT usa ratired) 16h Kind of Business/Industry Brickyard Elamantary/Secondary (0-12) College (1-4or 5+) Forklift Operator 12th grade Porick Yard Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Surnama) Be 0 Harris Rose Watson 19a. Informant's Name/Ralationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, State, Zip Code) Warrington Smith-Son 2018 Northbourne Road, Baltimore Md 21239 Baltimore, 20b. Ptace of Disposition (Nama of camatery, crematory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Data 1 Bulial 2 □ Cramation 3 □ Ramoval from Stata □ Donation 5 □ Other (Specify) Dulaney Valley Cem. 7/13/2000 Dulaney Valley, Md Signatura of Funaral Sarvice Licens 22. Nama and Addrass of Facility March F/H WEst 4300 Wabash Ave, Baltimore Md 21215 Enter the disaasa, or complications that clused the death. Do not anter the mode of dying, such as cerdiac or respiratory arrest, or heert feilure. List only one ceuse on much line. **Physician** Ventricular Fibrillation /Medical fmmediate Gausa (Finat disaasa or condition Examiner rasulting in death) Myocardial Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaase or injury that initiated avants resulting in death) Lasf Dua to (or as a consequence of) nevosclevosis Physiclan/Medicai Dua to (or as a consequance of): nears P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown Records, þ 24a. Was an autopsy performed? 24b. Wara autopsy findings available prior to Completed complation of ceusa of death? The law 2 No 1 Yes 2 No 1 Yas of Vital 25. Was cesa referred to medical axaminar? Be 26. Placa of Daath (Check only ona) Hospitat: Other: 4 Nursing Home 5 Residence 6 Other (Specify) edical Certification: To 1 Yas 2 No 1 Inpatiant 2 ER/Outpatient 3 DOA this 28a. Dete of tnjury (Month, Day Year) 27. Mannar of Deeth 28d. Describe how injury occurred 28b. Time of Injury 28c. Injury at Work? After Division or Attending 5 Panding invastigation 1 Natural 2 Accidant s after dea. 1 Yas 2 No 28f. Location (Street and Number or Rurel Route Number, City or Town, Stata) 6 Could not be datarmined 3 Suicide 28a. Place of tnjury - At homa, farm, straat, factory, office building, atc. (Specify) filled in by 4 ☐ Homicide To the Hospital within 24 hours hours 15 Certifying Physician: To the best of my knowledga, death occurred et tha tima, date and plece, end due to the ceuse(s) and mannar as stated.
2 Madical Examiner: On the basis of examination and/or invastigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and mannar stated. 29a. Cartifier completely 29d. Date signed (Month, Day, Year) 29b. Signatura and titla of certifier 29c. Licanse number 2000 30. Neme and address of person who complated cause of deeth (Item 23a) (Type, Print) eidel MID 31. Deta tiled (Month, Day, Year) 21239-2995 32. Registrar's Signatura State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2245 Certificate of Death

				Certificate of	f Death	,	Reg. No.	0 4	2410	
	1. Decedent's Name (First, Middle, Last)			512.0	2. Date of Death Month Dey Yeer 3. Time of Death				. Time of Death	
ysician Aedical	GEORGE NMN				WENDLING	JULY 9,			7:30 AM	
miner	4a Facility Name (If not institution, give st	reet end number)			4b. City, Town, or L					
	7975 CRAIN HIGHWA	V CIEN EOI	оръст	א די די די די	GLEN E	RIIDNTE	ΔN	NE ARUI	NDET.	
ī	5. Social Security Number 6. Sex		yrs. last birth	nday) If Under 1 Yea	If Under 24 Hrs.				(State or Foreign	
	212 12 7007	X M 2□ F 82 Yrs. Months Days Hours Min. (Month, Day, Year) AUG. 1, 1917 MARYLAND						AND		
28a-f show notified at rector	Usual Residence of Decedent 10a. State 10b. County	100	c. City, Town	or Location				104	Inside City Limits	
									1 ☐ Yes 2XNo	
	MARYLAND ANNE ARU	NDEL	G	LEN BURNIE						
Funeral Director	10e. Street and Number 7975 CRAIN HIGHWAY, GLEN FOREST APT. 3 21061 10g. Citizen of Whet Country? U.S.A.									
ner	11. Merital Status 12. Was Decedent E Armed Forces?		in U,S.	13. Wes Decedent of	Hispanic Origin? (Specify Yes or No ban, Mexican, Puerto Rican, etc.)		o- 14. Rece - American Indian, Bieck, White, etc.		ndian,	
	1 Never Married 2 Merried 3 Widowed 4 Divorced	XXYes 2 No1! If Yes, Give Yeer or Dates: 1!	01945- 1□ Yes 21XN				Specify: WHITE		WHITE	
	15. Decedent's Educa (Specify only highest grade		1000	Decedent's Usual Occi Give kind of work don	e during most of worl	king	16b. Kind of B		ry	
no indiano	Elementery/Secondary (0-12)	Coilege (1-4or 5+)		life. DO NOT use retir TILLER	ed)		MONUMEN DISTRIL			
	17. Fether's Name (First, Middle, Last)					ne (First, Middle	e (First, Middle, Maiden Surneme)			
					KATHAU					
	19a. Informant's Name/Relationship (Type MRS - BERNICE WENDL		19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7975 CRAIN HIGHWAY, GLEN FOREST APT. 3, GLEN B MD. 210					N BURNIE		
1	20a. Method of Disposition		Ob. Plece of cemetery	Disposition (Name of cremetory or other pl	lace)	Date	20c. Location -			
	1 District 2 Cremetion 3 Linemoval from State					PER LLC	. STEVE	NSVILL	E. MD.	
Ì	21. Signeture of Funeral Sarvice Licenses 22. Name and Address of Fecility SINGLETON FUNERAL H 1 SECOND AVENUE, S.W., GLEN BURNIE,									
	1 Julie									
	Part File the disease or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximate Interval Between the course on each line.								erval Between	
	Immediate Course /Final								set and Deeth	
	Immediate Ceuse (Finel disease or condition resulting in deeth) A Clisease Due to (or es a consequence of):							2 weeks		
_	resoning in death)			onsequence of):					2 weeks	
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Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Lest Due to (or as a consequence of):										
2										
200	Part II. Other significant conditions contr	ntributing to death but not resulting In the underlying cause g			iven in Pert I. 23b. Did tobacco uee co			ntribute to the causa of death?		
Completed by Physician						1 Yee 2 No		3 Probably 4 Unknown		
3						24a Wee	en autopsy	24b. Were	autopsy findings	
							med?	availat	ole prior to	
								of dee	th?	
		od in es				101	es 2000	1 🗆 Yı	is 2 No	
3	25. Was case referred to medical examiner?	20.1 Bits 01 Death (Criefly Orle)								
ion: To Be	1 Yes 2 No	Hospital: 1 inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Spec								
	27. Menner of Death 1 ☑Natural 5 ☐ Pending	28a. Dete of Injury (Month, Dey Yea	28b. Ti	me of uny 28c. Inj	ury et ork?	28d. Describe I	scribe how injury occurred			
3	2 ☐ Accident investigation				☐Yes 2☐No					
Certification:	3 Suicide 6 Could not be determined				28f. Location (Street and Number or Rural Route Number, City or Town, State)					
completely filled in by the	29a. Certifier (Check only one) 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner es stated. 2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and manner stated.								d. cause(s)	
	29b. Signeture and title of cartifier			29c. Licer	29c. License number			29d. Date signed (Month, Dey, Year)		
	on he			DU	240519			7/12/00		
-					/	1,12,00				
	30. Name and address of person who com	pieted cause of deeth	(Item 23a) (T		A 1	7111				
	1845 OAKWOOD	1 Rd	FIEN	BURNIC	nd.	2/06/				
te	31. Date filed (Month, Dey, Year)	32. Registrar's S	ionature	1						
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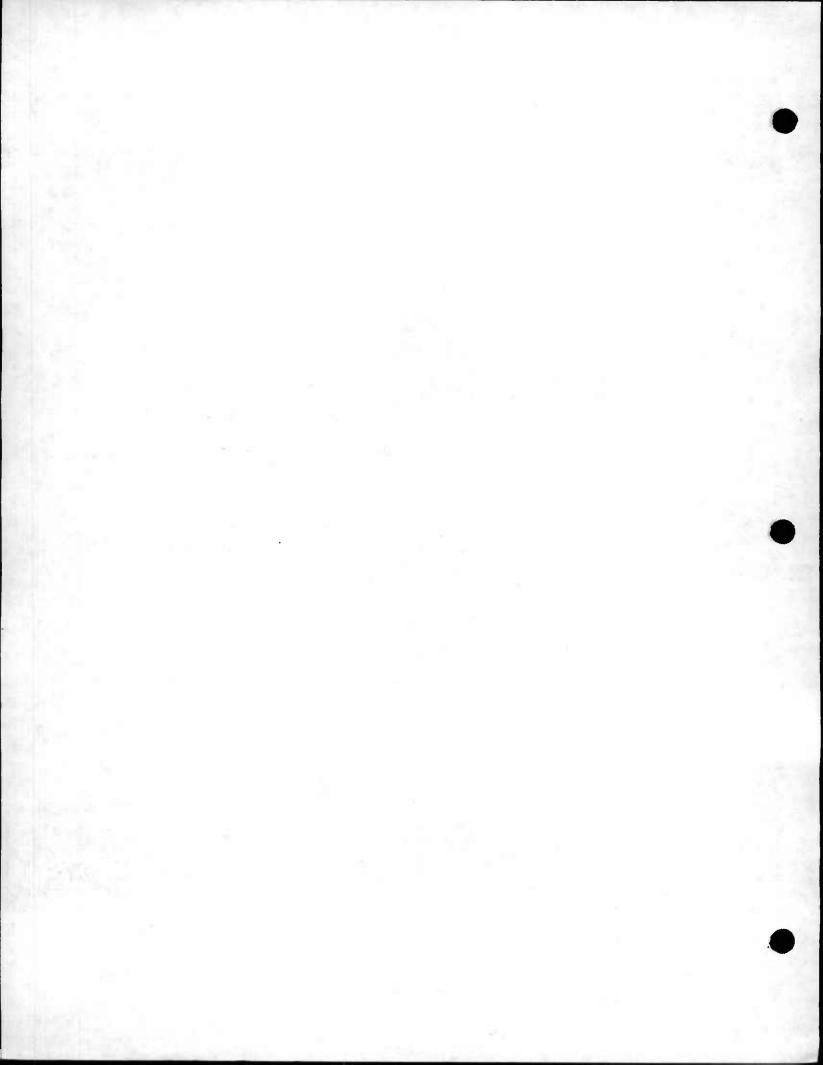
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/Medical	4	Camille a Facility Name (li		Wright	number)					th City Toy	wn or lo	JULY cation of Deat	12	2000	3:55 A	
Examiner	90	SINAI H		ive street end r	num <i>berj</i>								46. 0	County of Death	0	
	5.	Sociel Security N		Sex	7. Aq	e (In vrs. i	last birthdey	If Under		BALTI If Under			th	9 Rint	holace (State or Fo	
uneral irector		12-33-08		1□ M 2□XF	1		Yrs.	Months	Days	Hours	Min.	8. Dete of Bir (Month, De		1 -	hplace (State or Fountry)	
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T Plos		Oa. Stete	10b. County			10c. City	y, Town or L	ocation							10d. Inside City Li	
oto	Ma	aryland				Balt	imore				1				1 Ty Yes 2 □	
or items 23s or 28s-4 show immer must be notified at 7 Funeral Director	10	0e. Street and Nun	nber					10f. Zip	Code				10g. Citize	en of What Co	untry?	
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r Rems 234	11	1. Marital Status		12. Was De Armed I	Forces?		S. 13.	Was Deced	lent of H lify Cuba	lispanic Orig an, Mexican	gin? (Spe i, Puerto I	cify Yes or No Rican, etc.)	- 14	 Race - Amer Biack, White 		
by F		1 XNever Marri 3 ☐ Widowed	ed 2 Married	1 ☐ Yes If Yes, 0 Year or	Give	lo		1 ☐ Yes 2	No	Specify:			S	Specify: Bla	ick	
		3 B 11100#80	15. Decedent's I		Dates.		16a Dece	edent's Usua	I Occum	etlon				d of Business/I		
			ify only highest g	rade completed			(Give	B kind of wor DO NOT us	k done d	during most	of worki	ng				
ther than "naturn and, the Medical I	5	Elementary/Second	ndary (0-12)	College	(1-4or 5	+)	Stud						Edu	cation		
5 e		7. Father's Name (First, Middle, Las	st)						18. Mothe	r's Name	(First, Middle				
A .		John Wri	ght							Gwen	doly:	n James	3			
a marks aumatic To	11	9e. Informant's Na	me/Relationship	(Type, Print)			19b. Maii	ing Address	(Street	end Numbe	er or Rura	Route Numb	er, City or	Town, Stete, Z	ip Code)	
14		Gwendoly:	n Wright	/ Moth	ier		2900	Viole	et A	ve.,	Balt:	imore,	Mary:	land 21	.215	
2 2 0	20	Da. Method of Disp	osition Cremation 3			20b. P	lace of Displametery, cre	osition (Nem	ne of ther plea	ca)		Date	20c. Loca	ation - City or	Town, State	
Important: If any Injury or once.		4 Donation	Zion	Zion Cemetery 07/18/00						Landsdowne, Maryla						
Important: any injury o	21	21. Signature of Funeral Service Licensee 22. Name end A									end Address of Facility Derrick C. Jones Funeral Home Park Heights Ave., Baltimore, Maryland					
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State Registrar

DHMH 16 Rev 6/95

111 Penn Street, Baltimore, Maryland 21201



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State of Maryland / Department of Health and Mental Hygiene 2241 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Tima of Death Day Month Year **Physician** 2000 12 : 32 P4 Walter Warren Sr. /Medical 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) 4c. County of Death Examiner STUAT HOPETAL BALTILLORS OF BALTIMORE If Under 24 Hrs. Hours Min. If Under 1 Yes Birthplace (Stete or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months **™** 2□ F Director 219-16-9859 10/04/1925 Maryland Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10d. Inside City Limits 10b. County r than "natural", or items 23s or 25s-f show the Medical Examiner must be notified at 1 XYes 2 No Directo Maryland Baltimore 2 10f. Zin Code 10g. Citizen of What Country? 10e Street and Number 2909 Dupont Avenue 21215 Funeral U.S.A. 14. Rece - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S Armed Forces? 1 Q/ Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1943 1 TYes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0020 1 Yes 2 No Specify 1945 Specify: Black by 3 □ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Unknown Engineer GSA Fort Meade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 should be f and Mental h is marked Walter Warren Blanche L. Worrell 19e. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Nem 27 is m 2909 Dupont Ave., Baltimore, Maryland 21215
ace of Disposition (Name of Date 20c. Location - City or Town, State Bernetta Warren / Daughter Baltimore, 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore National Ceme. 07/17/00 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name end Address of Fecility Derrick C. Jones Funeral Home 21. Signature of Funeral Service bipensee 4611 Park Heights Ave., Baltimore, Maryland 21215 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cerdiac or respiretory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediete Cause (Final diseese or condition resulting in deeth) · MULTISOSTELL 2 days ORDAN FATURE WITH SEPSIS Examiner Due to (or as a consequence of): Examiner SETTUKES Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initieted events resulting in death) Last Due to (or as a consequence of): Box 68760. RHABIOMUPHISTS The law requires that the death certificate be Physician/Medical Due to (or as a consequence of) SEVERE HPOCILIC SUCH 23b. Did tobacco use contribute to the cause of death? P.O. Pert ff. Other significant conditions contributing to deeth but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown FAILURE, PERTPHERAL by Division of Vital Records. 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to Completed ALCOYUL ABUSE completion of cause of death? certificate has 1 Tyes 1 ☐ Yes 2 ☐ No Physician: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 10 1 Yes 2 No this erai Director: After thi filled in by the funeral Certification: 27. Menner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred i or Attending P 1 Satural 5 Pending investigation 1 Yes 2 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funeral Completely filled Certifying Physicfan: To the best of my knowledge, death occurred at the time, date end plece, end due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. edicai 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture end title of certifie D0052122 Name and address of person ho completed cause of death (Item 23e) (Type, Print) 2401 W. BELVEDERE AVE, BALTIMORE, MO 21215 PETA-CAT JACUSON BOOTH, MD

DHMH 16 Rev 6/95

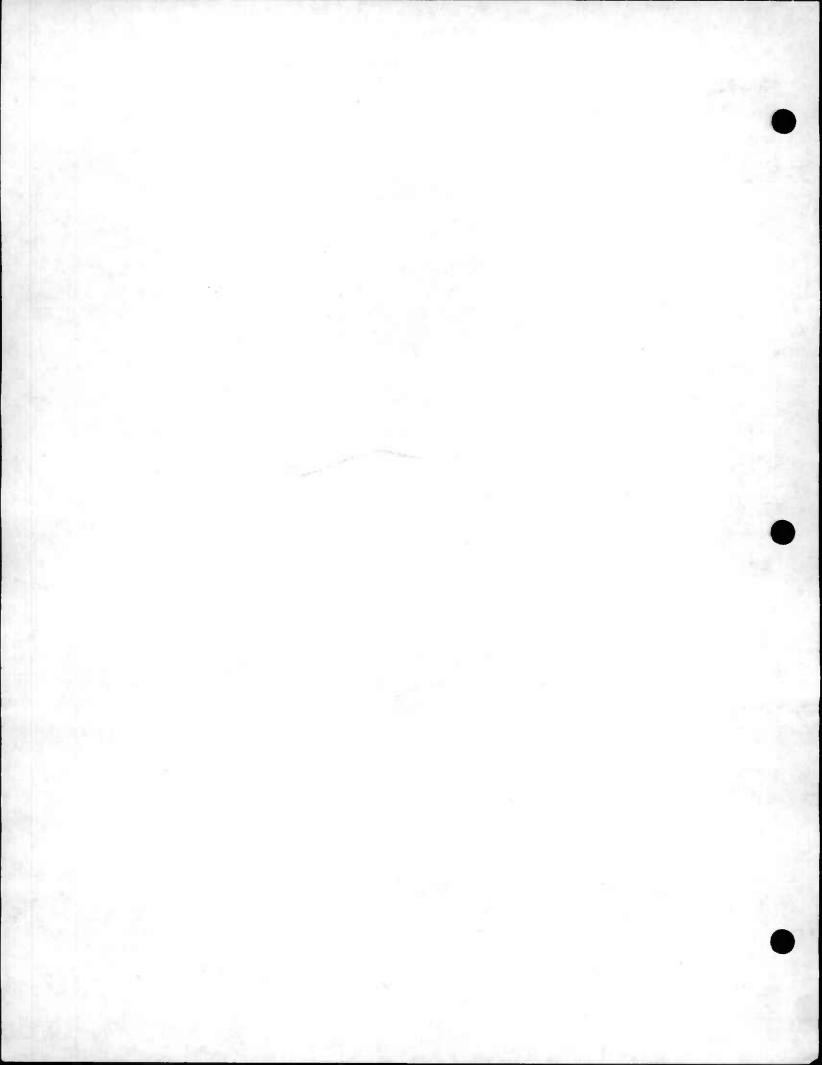
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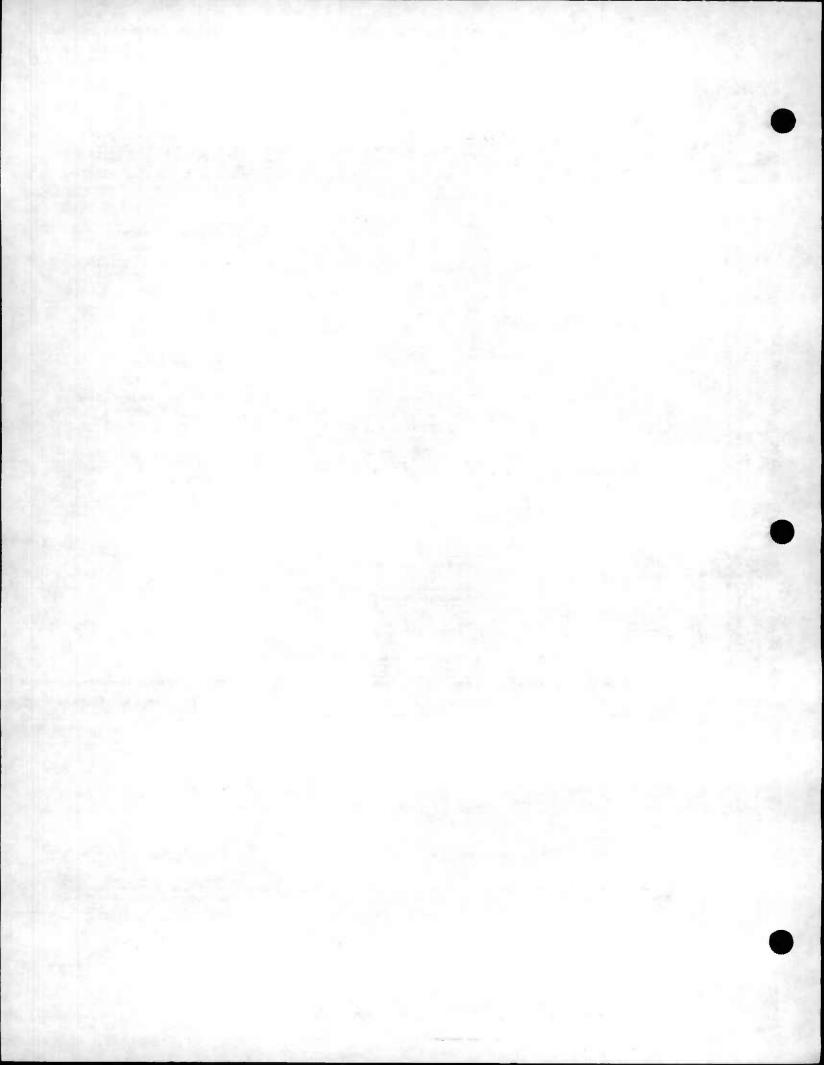
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State of Maryland / Department of Health and Mental Hygiene 00 221, 18

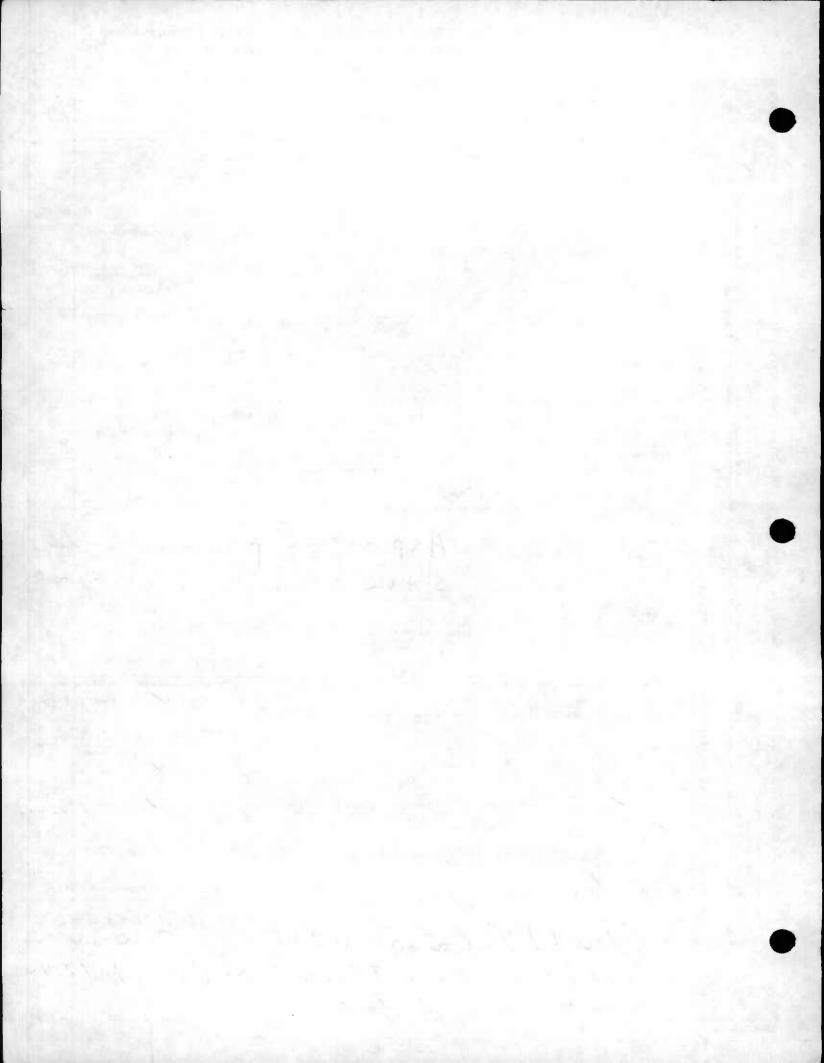
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State of Maryland / Department of Health and Mental Hygiene 00 224 19

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ati	2 ☐ Acci	dent invastigeti				М	10	Yes 2	No				
H	3 ☐ Suic	datamina	d 286. Place	of Injury - At he		reet, facto	ry, office			28f. Location	(Straet and Num	ber or Rur	al Route Number,
Certification:	7		Dundi	ing, atc. (opecin)	"					Only or 10	mi, olulo)		
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edicai	(Check o	only 2 Medicai Exa	eminer: On the be	asis of examina	tion and/or in	vestigatio	n, in my o	pinion, des	ath occur	red at the time	date and place	, and due t	o the cause(s)
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	30. Name an	d address of person who	o completed caus	e of death (Item	23e) (Type,	Print)							
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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** Carroll John Williams JULL ,2000 5:21AM /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death **Examiner** Baltimore Hospital sedale tranklin enter Square 0 If Under 1 Year If Under 24 Hrs. 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1₽M 2□ F Director 59 Jan. 16,1941 Maryland 214-38-6935 Usual Residence of Decedent death with the Maryland 10a. Stata 10b. County 10c. City, Town or Location 10d. insida City Limits Itam 27 is marked other than "natural", or itema 23a or 28a-f show other traumatic event, the Medical Examiner must be nothled at 1 Yes 20XNo Funeral Director Middle River Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21220 810 Thimbleberry Road United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? Race - American Indian, Black, White, etc. be filed within 72 hours after 1 Yes 2 No 1 Never Married 27 Married Maryland 21215-0020 1 Yes 2 No Specify: Be Completed by Specify: 3 Widowed 4 Divorced Year or Dates: White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedant's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Businass/Industry al Hygiene. Elamantary/Secondary (0-12) College (1-4or 5+) Carpet Sales Not Known Salesman 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fil ment of Health end Mental H lant: If Itam 27 Is marked oth Charles Williams Catherine Emkey 19a, Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Faye Williams (Wife) 810 Thimbleberry Road Middle River, MD 21220 20b. Placa of Disposition (Name of 20c Location - City or Town, State Date 20a. Method of Disposition emetary, crematory or other place) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata Department of Important: If any Injury or Dace. Towson, Maryland litop Service Corp. 7/10/2000 4 ☐ Donation 5 ☐ Othar (Specify) 21. Signature of Fu geral Service Licensee 22. Name and Address of Fscility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland Approximete Intarval Between Onset and Death 23a. PartT. Enter the disease, or complications that caused the shock, or haart failura. List only one cause on each line. eth. Do not enter the mode of dying, such es cardiec or respiratory errest, **Physician** /Medical Immediate Cause (Finel disease or condition resulting in death) Examiner by Physician/Medical Examiner icular The law requires that the death certificate be executed attending physician and for use as the burial-trans Sequentially list conditions, if any, leading to immediate causa. Enter Underlying Cause (Disaasa or injury that initiated events resulting in death) Last Due to (or as a consequence of) 68760. Due to (or as a consequence of): Box (P.0. Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yss 2 No 3 ☐ Probably 4 ☐ Unknown Hypertension of Vital Records, 24b. Wara autopsy findings available prior to completion of cause of daath? pege 2 should Be Completed 24a. Was an autopsy performed? this certificate hes 2 No 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: 25. Was case raferrad to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Tima of 28d. Describe how injury occurred After Division 1 Natural 2 Accident 5 Pending Injury ours after death. weral Diractor: Aft filled in by the fur 1 ☐ Yes 2 ☐ No invastigation 6 Could not be datarmined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, tarm, street, factory, office building, atc. (Specify) 4 Homicide To the Hospital of within 24 hours at To the Funeral D 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated. edical 29a. Certifier completely 1 29d. Date signed (Month, Day, Year) 29b. Signature end title of certifier 29c. Licensa number 2000 30. Name end address of person who completed cause of death (Item 23e) (Type, Print) Drive Baltimore, MD 9000 Franklin Square SunilAhui

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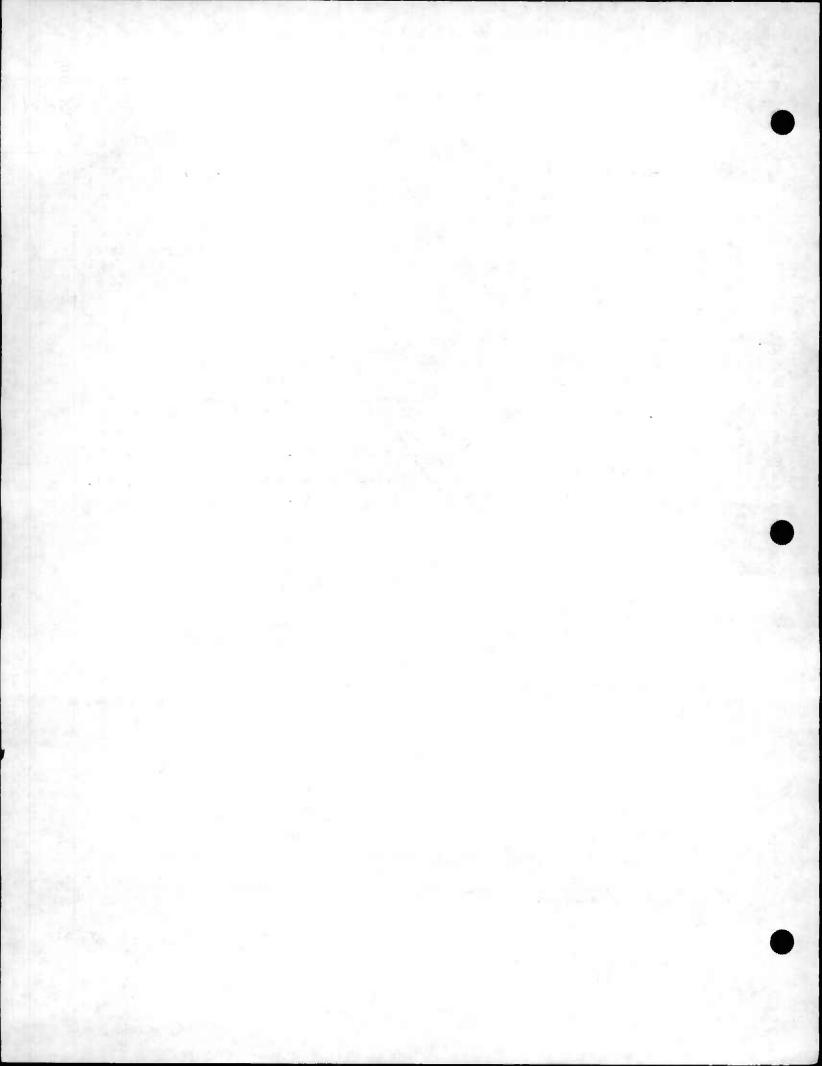
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31. Dete filed (Month, Day, Year)

JUL 1 4 2000

lilliams,

32. Registrar's Signature



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WILLIAMS HOMAS JULY 610 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street end number) 4c. County of Death Baltimore City Good Samaritan Hospital If Under 1 Yeer | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthdey) 8. Date of Birth (Month, Dey, Year) Birthplace (State or Foreign Country) Deys Months \$D\$M 2□ F Yrs. 219-52-3612 53 Jan. 14,1947 Maryland Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits txBXYes 2 □ No Maryland N/A Baltimore City 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3034 Fleetwood Avenue 21214 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 1 Never Married 2 Merried tXYes 2 No If Yes, Give 1 Yes 2 No Specify: Specify: 3 ☐ Widowed 4 ☑Divorced Year or Dates: Vietnam White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Years Exterminator Pest Control 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Charles T. Williams Catherine Emkey 19b. Mailing Addrass (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mrs. Catherine Williams (Mother) 3034 Fleetwood Ave. Baltimore, MD 20b. Placa of Disposition (Neme of cametery, cremetory or other pleca) 20c. Location - City or Town, Stete 20a. Method of Disposition Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Hilltop Service Corp. 7/12/2000 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility 21. Signeture # Funerel Service Licensee Duda-Ruck Funeral Home of Dundalk, Inc. are 7922 Wise Ave. Dundalk, Maryland 21222 Approximata Interval Between Onset and Death complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. LIVER FAILURE

Due to (or as a consequence of):

LIVER CIRAHOSI

Due to (or as a consequence of): Immediate Cause (Finel Ulay disease or condition resulting in death) Grais Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Last Grass ALCOHOLISM 23b. Did tobacco use contribute to the causs of death? 1 Yes 2 No 3 Probably 4 thomknown delli fina 24b. Were autopsy findings evailable prior to 24a. Wes en eutopsy completion of cause of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 26. Place of Deeth (Check only one)

Physician /Medical Examiner

Physician

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r than "natural", or flems 23s or 28s-1 show the Medical Examiner must be notified at

filed within 72 hours after death with the Maryland

Hygiene.

Pages 1 and 2 should be 1 nent of Haalth and Mental I int: If item 27 is marked of

7 is marked other traumatic avant, I

Department of Haalth Important: If Itam 27 any Injury or other to pnce.

Baltimore, Maryland 21215-0020

Box 68760.

P.O.

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Physician/Medical Examiner

physician the buria After this To the Hospital or Attanding Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral

Registrar

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ Completed 25. Was case referred to medical examiner? Be Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No edical Certification: To 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Deeth 28c. Injury at Work? 5 Pending investigation 1 Natural 1 Yes 2 No 2 Accident 28f. Location (Street end Number or Rurel Route Number, City or Town, Stele) 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, term, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piece, end due to the cause(s) and menner as stated.

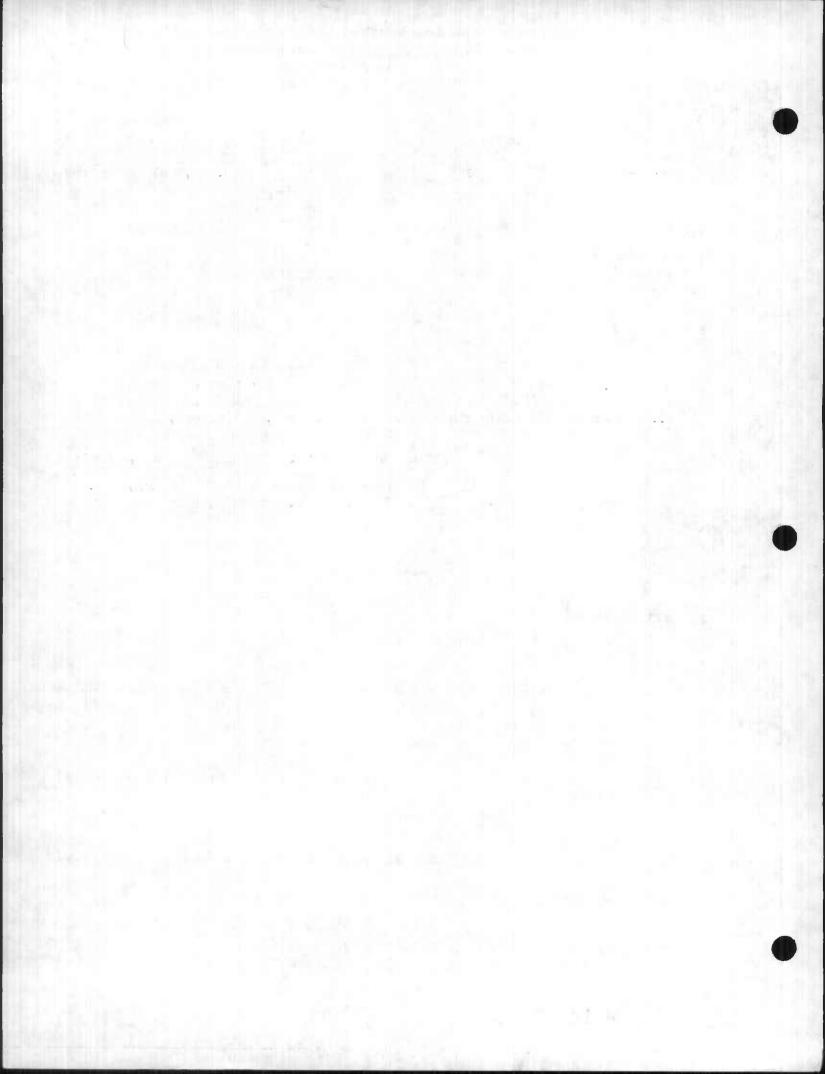
2 Medical Examiner: On the basis of examinetion and/or invastigation, in my opinion, death occurred at the time, dete and pieca, and due to the ceuse(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier

31. Dete filed (Month, Dey, Year) JUL14

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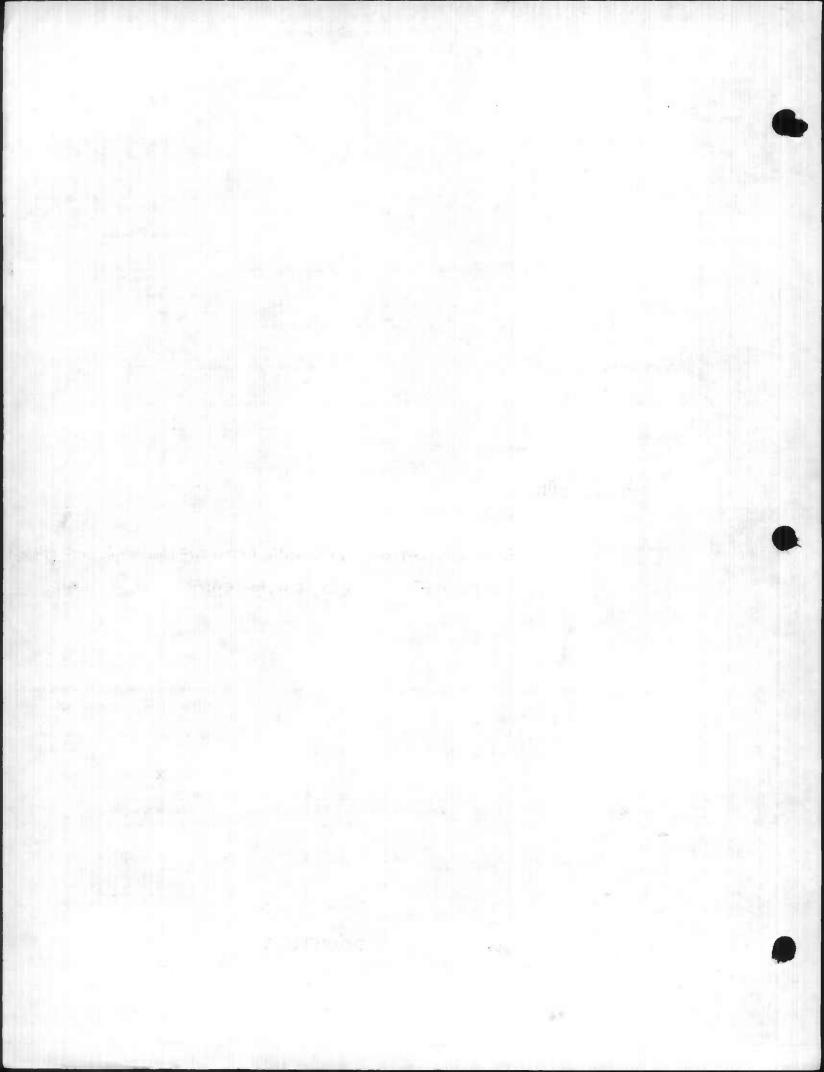
30. Name and address of person who completed cause of death (Item 23a) (Typa, Print)
WENGUSA RAVARRO, MD-560/ Foch Raven Bonlevard, Baltiman MD. 21239 32. Registrer's Signature Deper

M-0-D.



Please Type or Print in Biack Indelible Ink. Assure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month **Physician** Charles Parmele Wise, Sr. July 2000 6:20 PM /Medical 4a Facility Neme (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner St. Joseph Medical Center Towson Baltimore If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Deys Months Hours 1 M 20 F Yrs 220-20-6225 **Director** June 26, 1929 Illinois Usual Residence of Decedent 10c. City, Town or Location 10a, Stete 10b. County 10d. Inside City Limits 28a-f ahow ral', or items 23s or 28s-f shore Examiner must be notified at 1 ☐ Yes 2 No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 600 Stevenson Lane 21286 United States death Funeral 12. Wes Decedent Ever in U,S. Armed Forces? 1 ☑ Yes 2 □ No KODO if Yes, Give Yeer or Detes: Want I 13. Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Bleck, White, etc. hours after 1 ☐ Never Married 2 ☐ Merried Korrean 'natural', or altimore. Maryland 21215-0020 1 ☐ Yes 2 ☒ No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced War Era White Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within 72 Hygiene. College (1-4or 5+) 5+ Eiementery/Secondery (0-12) permit. Pagas 1 and 2 should be filed with Department of Haath and Mental hygient Important: if item 27 is marked other than any injury or other traumatic event, that once. Executive Retail 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Gerald Sillman Wise Louise Berry 19a. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Isabella S. Wise (Wife) 600 Stevenson Lane Towson, Maryland 21286 20b. Piece of Disposition (Name of cemetery, crematory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 □ Burlal 2 OCremetion 3 □ Removel from Stete 4 ☐ Donetion 5 ☐ Other (Specify) Green Mount Crematory 7/12/00 Baltimore, Maryland 21. Signeture of Funeral Service Licensee 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. 6500 York Road Baltimore, Maryland 21212 Steven I. Sult 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death **Physician** /Medical Immediate Ceuse (Finel of CHRONIC OBSTRUCTURE NMONARY DISEASE (14dm) EXACLEMBATION disease or condition resulting in deeth) Examiner Due to (or as a consequence of): Examiner YEARL SEVENUE COPD attending physician and for use as the burlal-transit that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Box 68760. Physician/Medical Due to (or es a consequence of): Pert II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? Records, P.O. 1 | Yes 2 | No 3 | Probably 4 Munknown þ 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 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To the Hosp within 24 ho To the Fune completaly fi (Check only one) 2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, deeth occurred at the time, date end piece, end due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signeture and title of cartifier D0047625 July 11, 2000 MD 30. Name and eddress of person who completed cause of deeth (item 23a) (Type, Print) W Richard O'Malley, M.D. 7600 Osler Drive, Suite 311 Towson, Maryland 21204 31. Date filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent'a Name (First, Middle, Last) 3. Tima of Death 2. Dete of Deeth Month WAlls Kobert Dulin 2000 0739) W 4a Fecility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth PENINSULA REGIONAL MEDICAL CENTER SALISBURY WICOMICO If Under 1 Yeer | If Under 24 Hrs. Montha Days Hours | Min. Birthpiece (State or Foreign Couptry) 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Dey, Yeer) Days 100M 2DF 221 12 6282 15 Yrs. Miltord Dec. 23, 1924 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits DE 1 ☐ Yes 2 XNo KENT 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 19963 6440 U.S.A. nateau 14. Reca - American Indien, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Orlgin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 11. Merital Stetus 1 Tyes 2 No WUT 1 Never Merried 2 Married If Yes, Give Year or Dates: 22 15 1 Yes 200 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 12 18. Mother's Neme (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) William Riley ANNA Dulin WAlls 19e. Informent's Neme/Relationship (Type, Print) Wife 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 6440 Chareau Dr. Milford, De MARGETY Ann 20b. Pleca of Disposition (Name of cametery, cremetory or other placa) 20c. Location - City or Town, Stata 20a. Method of Disposition Dete 1 Buriel 2 Cremetion 3 Removel from Stete 4 Donation 5 Other (Specify) 7/10/00 CAPITOL CREMATORY DOVER, DE 22. Name and Address of Facility Makes Tr Funeral Home 21, Signeture of Funeral Service Licensee Lewis D. Mckrott 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Finel · MULTIPLE ORGAN DEFINITION disease or condition resulting in death) Due to (or as a consequence of): MATERIAN MYOCHRAM Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es a consequença of): - CO CONTRY PUTERY BYPASS. Due to (or as e consequence of): 3 duays 2FDO -Alrew, DISEME coronaly Pert II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 3 Probably 4 Unknown 24b. Were eutopay findings evelleble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical 26. Piece of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 8 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28e. Date of Injury (Month, Dey Year) 27. Manner of Death 1 Netural 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rurel Route Number, City or Town, State) 3 ☐ Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, offica building, etc. (Specify)

Kobert Walls Division

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Examiner

Funeral

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Medical Certification: To

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29e. Certifier (Check only one) 29b. Signature and title of cert

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To the Hospital o within 24 hours af To the Funeral DI completely filled in

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Registrar **DHMH 16 Rev 6/95**

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1 Pertifying Phyeician: To the best of my knowledge, deeth occurred et the time, date end pleca, and due to the cause(s) and manner es atated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner steted.

29c. License number

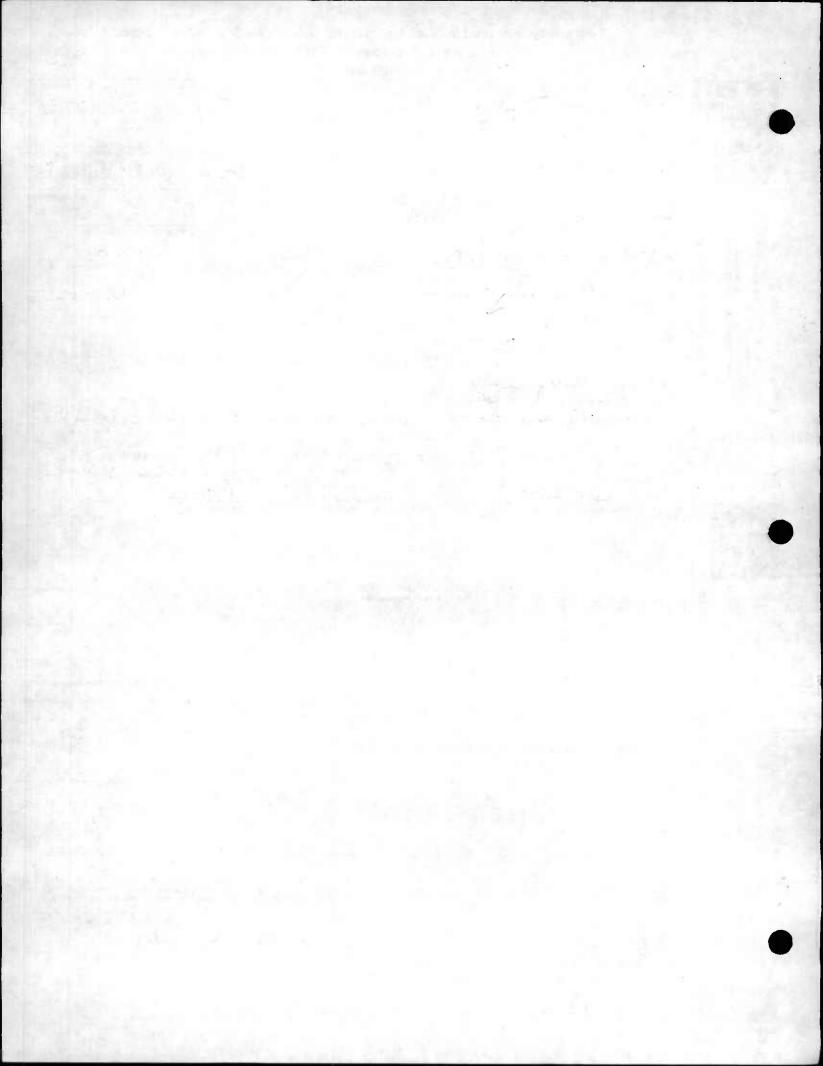
SALISBURY MD

29d. Date signed (Month, Dey, Year)

30. Name and address of person who completed cause of deeth (Item 23a) (Type, Print)

C-TODD ZOI PINT BUTT CD

32. Registrer's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Data of Death Month **Physician** Bernard George Yekstat /Medical 4a Facility Nama (If not institution, giva street and number) 4b. Cjty, Town, or Location of Death 4c. County of Death **Examiner** Nursing Haure de Grace 7. Aga (In yrs. last birthday) If Under 1 Yaar | If Under 24 Hrs. 5. Social Security Number Birthplaca (Stata or Foreign Country) **Funeral** Months Days 10M 20 F Yrs. 212-05-6976 Director 86 1913 Maryland Usual Rasidance of Decedant 10a. Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 ☐ Yas 2 ☑ No Director ed other than "natural", or items 23s or 28s-f event, the Medical Examinar must be notified Maryland Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizan of What Country? Натте 23а от 1217 Hickory Brook Court Funeral 21014 14. Raca - Amarican Indian, Black, Whita, atc. 12. Was Decedent Evar in U,S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 1 Yas 2V No If Yas, Giva Year or Datas: 1 Nevar Married 2 X Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Businass/Industry Elemantary/Secondary (0-12) Cottege (1-4or 5+) 12 Manager Stainless Steel permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If them 27 is marked othn any injury or other treuments event. 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maidan Surname) Be Adolph Yekstat Fronika Young 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) La Vera Mae Yekstat (Wife) 1217 Hickory Brook Ct. Bel Air, Maryland 21014
Data 20c. Location - City or Town, Stata 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 1 Burial 2 Cremation 3 Removal from Stata 7/15 4 □ Donation 5 □ Other (Specify) Holly Hill Memorial Gardens 2000 Middle River, Maryland 21. Signature of Funarat Sarvice Licenses 22. Nama and Addrass of Facility Bruzdzinski Funeral Home PA 23a. Part. Entar the disease, or complications that caused the death. Do not entar the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Essex, Maryland 21221 Approximata Intervat Batween Onsat and Daath **Physician** Immediata Causa (Finat disaasa or condition rasulting in death) /Medical Examiner bunal-transit Sequentially list conditions, if any, taading to immediata causa. Entar Undartying Cause (Disease or injury that initiated events rasulting in death) Last Physician/Medical Dua to (or as a consequence of): use as the Part II. Other eignificant conditions contributing to death but not rasulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Inknown ate has been signed by page 2 ahould be detac by 24b. Wara autopsy tindings available prior to completion of causa of death? 24a. Was an autopsy performed? Completed 1 Yes 2 No 1 ☐ Yas 2 ☐ No 25. Was casa rafarred to predical axaminar? 26. Place of Death (Check only ona) Other: 4☐ Nursing Homa 5☐ Rasidence 6☐ Othar (Specify) 1 Yas 2 Tho Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Data of tnjury (Month, Day Year) 27. Mannar of Death 28d. Describe how injury occurred 28b. Tima of 28c. Injury at Work? After Division 1 (Matural 5 Pending To the Hospital or Attendir within 24 hours after death. To the Funeral Director: A completely filled in by the fi death. t ☐ Yas 2 ☐ No invastigation 2 Accident 6 Could not be detarmined 28a. Place of Injury - At homa, farm, street, factory, office building, atc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 ☐ Homicida 1 Certifying Physician: To the best of my knowledge, death occurred at the tima, data and place, and due to the cause(s) and mannar as stated.

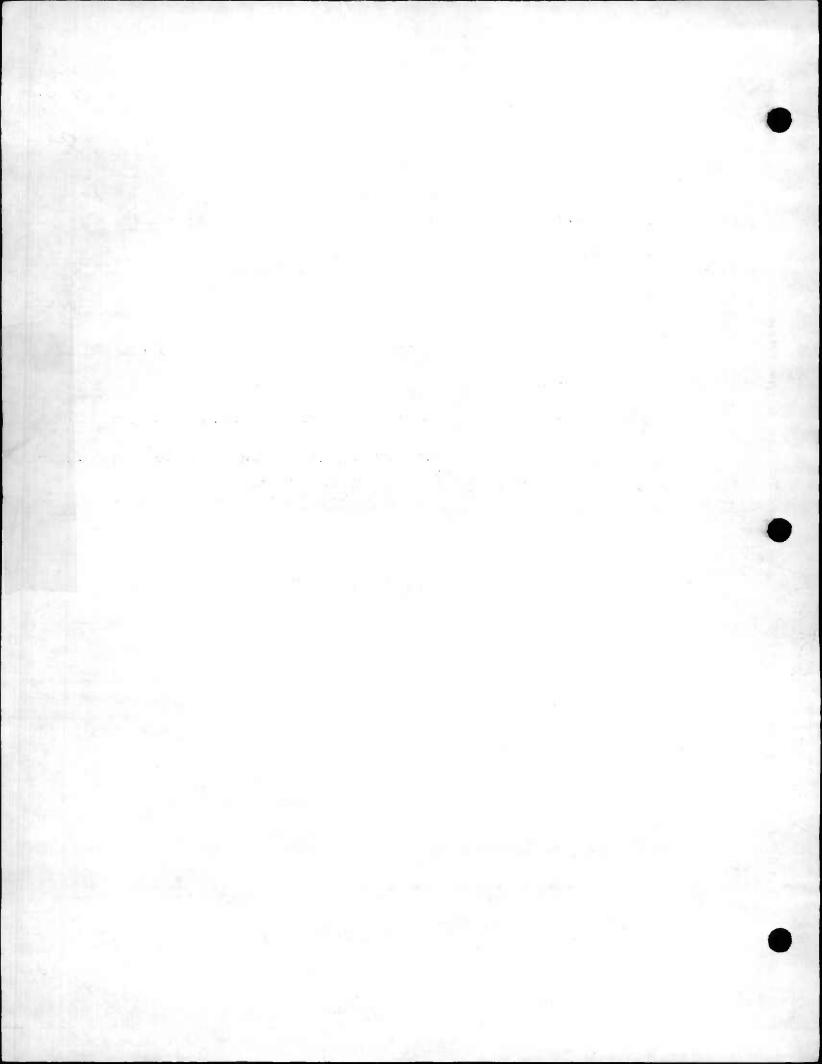
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) and manner stated. 29a. Cartifier (Check only one) 29b. Signatura and titla of certified 29c. License number 29d. Data signad (Month, Day, Year) (ttem 23a) (Type, Print) on Ave House DeGrace MD 21078 Tow Year) 31. Data filed (Month, Day, 32. Registrar's Signatura

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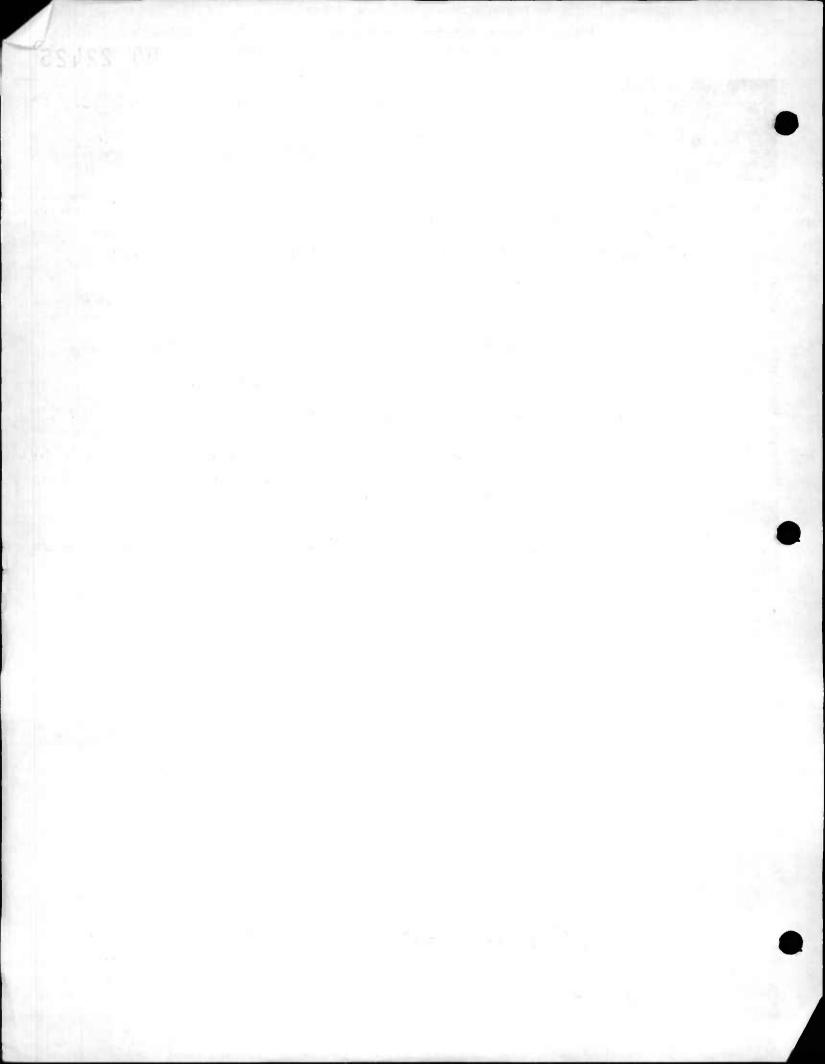
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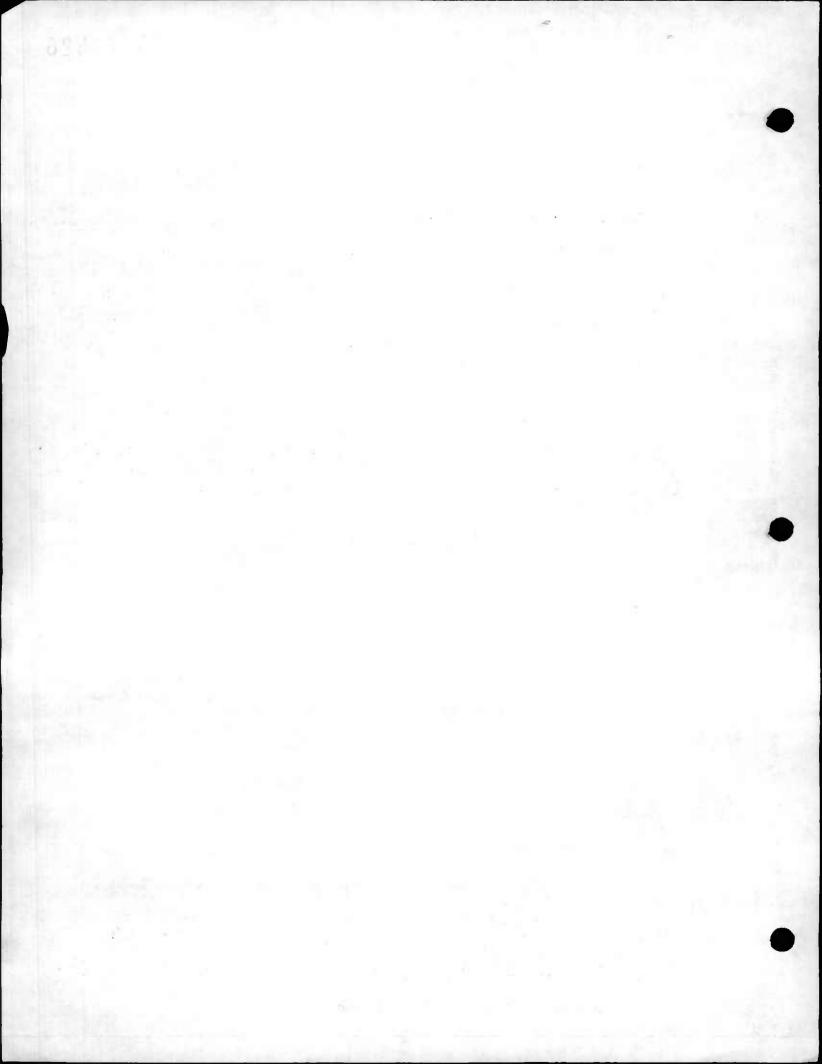
State of Maryland / Department of Health and Mental Hygiene U amend item 5 per fh G790 12/6/00 yf Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3 Time of Death **Physician** 13, 2000 20 Year July BERNARD FRANCIS 9:15AM ARMSTRONG SR. /Medical 4e Facility Neme (If not Institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 1001 Kirkcolm Road Baltimore Towson 5. Social Security Number 217-20-7673 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Year) March 14, 1911 7. Age (In yrs. last birthday) Birthplaca (Stete or Foreign Country) **Funeral** Deys Hours 1₩ 2□F Yrs Director 89 Maryland Usuel Rasidance of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Insida City Limits 28a-f show 1 ☐ Yes 2 ☐ No Director Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? ò 238 1001 Kirkcolm Road 21286 USA Funeral 12. Wes Decedent Ever in U,S. Armed Forces? XXXVes 2□No WWII If Yas, Give Year or Detes: "natural", or Items Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) 11. Meritel Stelus Race - Amarican Indian, Bleck, Whita, etc. pemit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiena. Important: if Item 27 is marked other than "natural", or Item any Injury or other traumatic event, the Medical Exertings page. 1 Never Merried 2 Merried Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: 2 ₩ Widowed 4 Divorced WHITE Completed 16a. Decedant's Usual Occupetion (Giva kind of work done during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) 5+ Bank Examiner State of Maryland 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Sumeme) Be William Armstrong Annie Maxfield 19e. Informent's Name/Reletionship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Catherine E. Armstrong DTR 94 Dunkirk Road Baltimore, Maryland 21212 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20a. Method of Disposition 1) Buriel 2 Cremetion 3 Removal from State Dulaney Valley Mem. Gar. 7/17/00 Lutherville, Maryland □ Donetion 5 □ Other (Specify) 22: Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc. 21 Signeture of Funeral Service Licer was 6500 York Road Baltimore, Maryland 21212 nnes lications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, Approximeta Intarval Batwaan Onset and Deeth **Physician** Myorardia Infantia Immediate Causa (Final disease or condition resulting In death) /Medical) winute Examiner Physician/Medical Examiner The law requires that the death certificate be executed tha burial-transi Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disaasa or injury Due to (or es e consequance of) P.O. Box 68760. that initieted events resulting in death) Last Due to (or es e consequença of) signed by the a Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contributs to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, ģ 24b. Were autopsy findings available prior to completion of cause of death? Completed director, page 2 should 24a. Wes an eutopsy performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No certificate of Vital Hospital or Attending Physician: Be 25. Wes case referred to medical 26. Place of Deeth (Check only one) Othar: 4 Nursing Home 5 Aesidenca 6 Other (Specify) 1 Yes 2N No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA nours after death.

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2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicida within 24 hours a To the Funeral D completely filled 1 Certifying Physician: To the best of my knowledga, daath occurred at the time, deta end place, and due to tha cause(s) and menner es steted.

2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, data end place, and due to the cause(s) and menner steted. 29e. Certifier To the 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) (Item 23a) (Type, Print) protuce Rd MAP VO 31. Dete filed (Month, Day, Year) 32. Registrer's Signetura State

Registrar

JUL 1 5 2000 **DHMH 16 Rev 6/95**



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22427 Certificate of Death AMENDED ITEM #19a PER FH G785 7/17/00 AH 1. Decedent's Name (First, Middle, Last) 2. Deta of Deeth 3. Time of Death Month Year **Physician** Jeorge 2000 /Medical 4e Facility Name (If not Institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** ant Itimore HODE If Under 1 Year 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplece (State or Foreign Country) **Funeral** Days 12M 20F 217-40-8345 Usual Residence of Decedent Yrs. Director Tarulan r 28a-f show 10a, Stete 10b. Count 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No altimore Director 10e. Street and Numbe 10f. Zip Code 10g. Citizen of Whet Country? ŏ 21205 Nerna 23a Funeral ton 12. Wes Decedant Evar in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexicen, Puerto Rican, etc.) 14. Race - American Indien, Bleck, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Interportant: If Item 27 is marked other than "natural", or han any injury or other traument. 1 ☐ Never Merried 2 ☐ Married Baltimore, Maryland 21215-0020 1 Yes 2 No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced 100 Completed 15. Decedent's Education (Specify only highast grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Furniture Morman 10 th byer 17. Fathar's Neme (First, Middle, Last) 18. Mother's Name (First, Middla, Maiden Sumema) Be revoil [Carol 19e. Informant's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rural Routa Number, City or Town, State, Zip Code) 0 20b. Plece of Disposition (Name of cametery, cremetory or other plece) 20a. Method of Disposition 20c. Location - City of Town, Stete 1 O Surel 2 Cre 4 Donation 5 C 7-17-2000 Ceneter Signature of Funyfal Service Lid 22. Nama and Address of Fecility Chare natilogora Miller's N Alto. Broadway Approximete Intervel Between Onset and Deeth ations that caused the death. Dones enter the mode of dylng, such as cerdiad or respiratory errest, Physician /Medical Immediate Causa (F disease or condition resulting in death) mediete Ceuse (Final onenths cobaderial Examiner Due to (or es e consequence of): Physician/Medical Examiner MUIRAL lears The law requires that the death certificate be axecuted Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): and P.O. Box 68760, Due to (or es e consequence of) use as the 23b. Did tobacco use contribute to the cause of death? Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown Records, Completed by 24b. Ware autopsy findings available prior to completion of causa of death? 24e. Was en eutopsy performed? etrovical denentia 1 Yes 2 No 1 ☐ Yes 2 TNo certificate Division of Vital or Attending Physician: 25. Was cese referred to medice! exeminer? Be 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospitel: 1 Yes 2 No Medical Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA this After thi 28e. Dete of Injury (Month, Dey Year) 27. Menner of Deeth 28d. Describe how injury occurred 28b. Time of 28c. injury et Work? ne Hospital or Attending in 24 hours after death. The Funeral Director: After pletely filled in by the fun 1 Naturel 5 Pending 1 Yes 2 No Invastigation 2 Accident 6 Could not be determined 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 🔁 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete and plece, end due to the ceuse(s) end menner as stated. completely (Check only one) 2 Medical Examiner: On the basis of examinetton end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and menner stated. To the I 29b. Signeture and title of certifie 29c. License number 29d. Dete signed (Month, Day, Year)

State Registrar

DHMH 16 Rev 6/95

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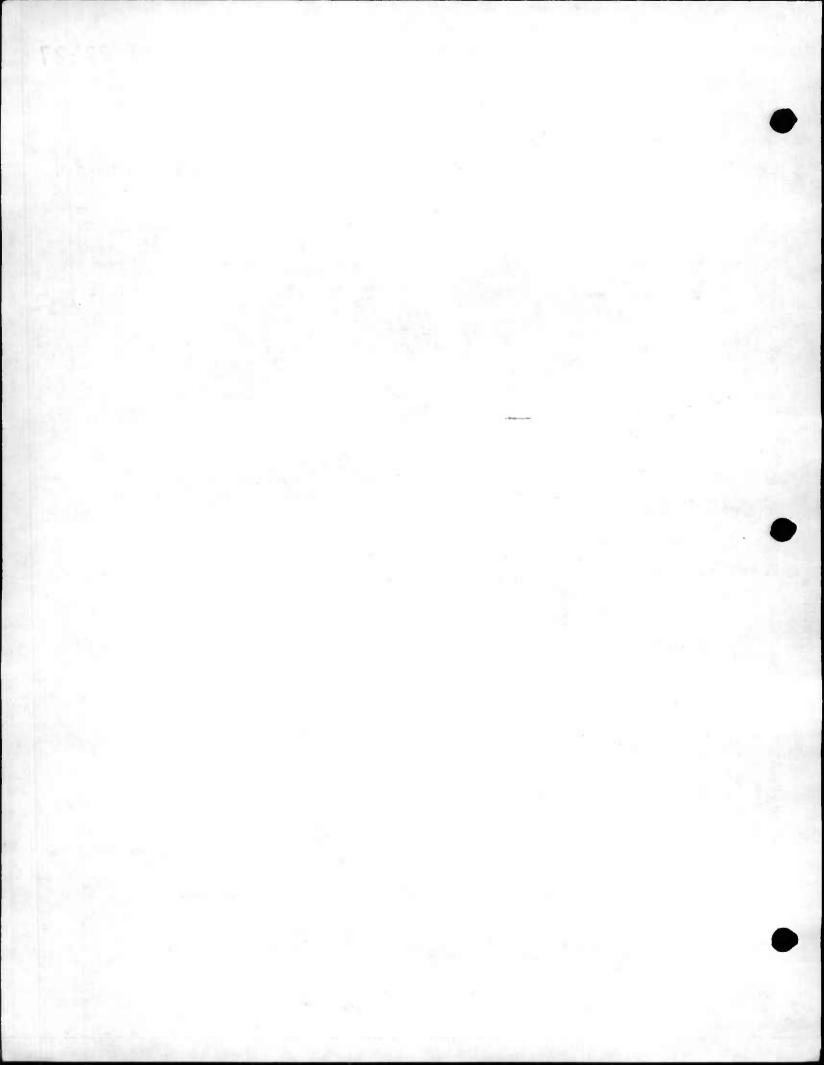
32. Registrar's Signeture

30. Name and address of person who completed causa of death (Item 23a) (Type, Print)

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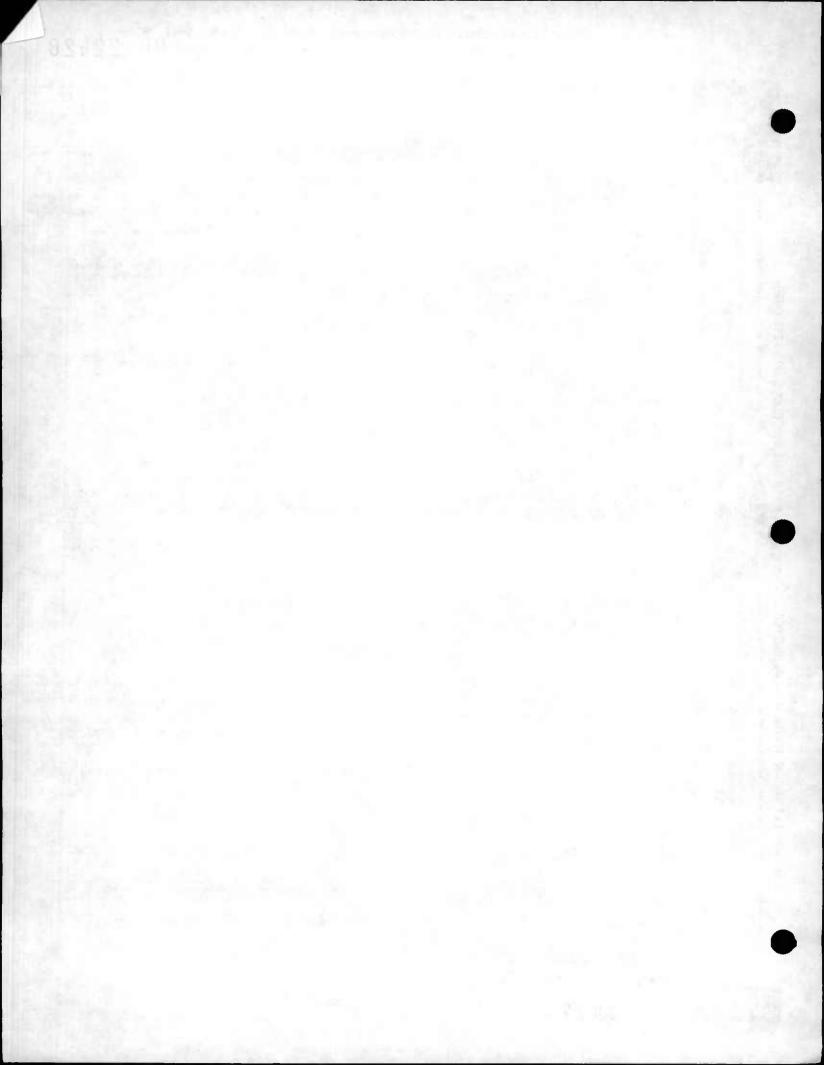
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State of Maryland / Department of Health and Mental Hygiene 0 0 22428

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00	30. Name and eddress of person who	2772	atn (Item 23a) (I	D A	20	57) 111	2121	1				
Chata	31. Date filed (Month, Dey, Year)	32. Registrar	's Signature	N	BASE	10 1000	ondy					
State Registrar	.1111 1 7	2000 150	MANA	B.	spor	Ks						



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene \(\int \) Certificate of Death AMENDED ITMES #24a.25 PER MD G785 7/20/00 AH . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth JUTY 1, Physician 2000 3:10 AM DORIS BEAVER /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** Anne Arundel Millersville KNOLLWOOD MANOR NURSING HOME | Hours | Min. | 8. Date of Birth (Month, Pay, Year) | Sept 10, 1925 If Under 1 Year Birthplace (State or Foreign Country)
 1-7. Age (In yrs. last birthday) **Funeral** Days 1□ M 2X F 219-18-5242 Vrs 74 Director Usual Residence of Decedent with the Meryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours efter death with the Meryler Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examples in noticed at page. MD 1 Yes 2 No Millersville Director Anne Arundel 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code 899 Cecil Avenue 21108 IISA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 ☐ Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2 No Specify: white Specify þ 3 Widowed 4 □ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Flemeniary/Secondary (0-12) Coitege (1-4or 5+) unk unk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 unk unk 19e. Informani's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, State, Zip Code) Knollwood Manor Nursin Home . 899 Cecil Ave Millersville, MD 21108 20b. Place of Disposition (Neme of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation _ 5 X Other (Specify) in state 21 Signature of Europeal Service Licensee Ronald S. Wade, 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street Director Allebace Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert failure. List only one cause on eech line. Approximate Interval Between Onset and Death **Physician** etastatic Carcinorna of Immediate Ceuse (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Examiner 017 5 mc 2 sician end buriel-transit law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequenca of): ettending physician for use es the burie Physician/Medical that initieted events resulting in death) Last Due to (or as a consequence of) signed by the e Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Tyes 2 No 3 Probably 4 Unknown 40RESS102 þ 24b. Were autopsy findings available prior to completion of cause of death? 24e. Was an autopsy performed? Completed peen hes tXXYes 2□No 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Wes case referred to medical Be 26. Place of Deeth (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28d. Describe how injury occurred Certification:

this certificate funeral

Baltimore, Maryland 21215-0020

P.O. Box 68760,

Records,

Division of Vital

28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigetion 1 Yes 2 No 2 Accident 3 Sulcide 6 Could not be

28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify)

29a. Certifier edicai

4 | Homicide

1 Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted.
2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the ceuse(s) end manner stated.

29b. Signature and title of cartifier

29d. Date signed (Month, Day, Year) 29c. License number

28f. Location (Street and Number or Rural Route Number, City or Town, State)

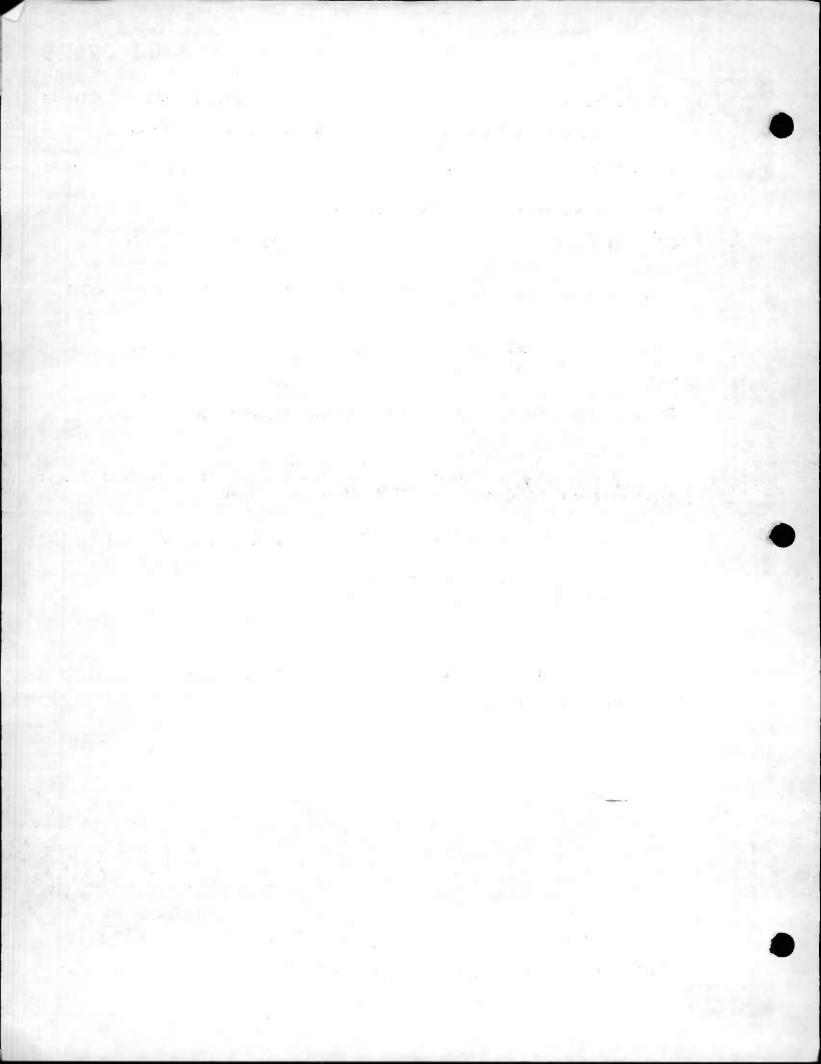
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1-102UC

Road

State Registrar 31. Date filed (Month, Day, Year)
JUL 17 2000 32. Registrar's Signature

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To the Hosp within 24 hou To the Fune completely fi



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22430 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year BACKERS MARY 12th ANN JULY 15:05 2000 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death BALTIMORE NIA LEVINDALE CENTER If Undar 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Aga (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 10 M 20 F Days 220.48.3959 Yrs. NC 09-01-02 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No MD NIA BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21215 USA 3503 ELLAMONT ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Raca - American Indian. Black, Whifa, atc. 1 Yes 2 No If Yes, Give Year or Datas: 1 ☐ Nevar Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: Specify: 3 Widowed 4 □ Divorced BLACK 16e. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) HOME DOMESTIC GRADE 6 114 NI A 18. Mothar's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RHODA MCAILISTER NHOL MELVIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ISABELLE WILLIAMS 3503 ELLAMONT RD., BALTO. MD. 21215 20b. Plece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State ARBUTUS CEMETERY BALTIMORE, MO 7.17.00 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensea 22. Name and Address of Facility C. GREENE FUNERAL UD. NATU PIKE, BAUTO. I SERVICE VAUGHIN C. MO. 21229 5151 Approximate Interval Between Onset and Death 23a. Pant. Enter the dileese, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or helicitarillure. List only one cause on each line. Immediate Cause (Final SEPS15 disease or condition resulting in death) 10 DAYS Due to (or as a consequence of): PNEUMONIA 5 DAYS Due to (or as a consequence of): I YEAR . DECUBITII Due to (or as a consequenca of): Part If. Other algorificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

Physician /Medical Examiner

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signed by the atter

page 2 s has

this funeral

After

To the Hospital or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fun

Physician/Medical

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Completed

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The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

of Vital Physician:

Division or Attending

Department of h Important: If its any injury or oth

Physician

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Examiner

10a. Sfate

Funeral

Director

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Pages 1 and 2 should

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Maryland 21215-0020

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24b. Wera autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 No

25. Was case referred to medical examiner? 26. Plece of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Mannar of Death 28a. Date of Injury (Month, Dey Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Neturel 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 281. Location (Street and Number or Rural Routa Number, City or Town, Stete) 3 Suicida 28a. Place of Injury - At home, ferm, street, factory, offica building, etc. (Specify) 4 Homicide 29a. Certifier

edical Certification: To 1 Cartifying Physician: To the best of my knowledge, death occurred et the time, date and placa, and due to the cause(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred et the time, date and placa, and due to the ceuse(s) and manner stated. (Check only one) 29b. Signature and title of certifier

29c. License number 29d. Date signed (Month, Day, Year)

JULY

2000

norna m 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ausley.

AVENUE, BALTIMORE 2434 W. BELVERERE MD 21215

m.D.

State Registrar

JUL 1 7 2000

31. Date filed (Month, Dey, Year)



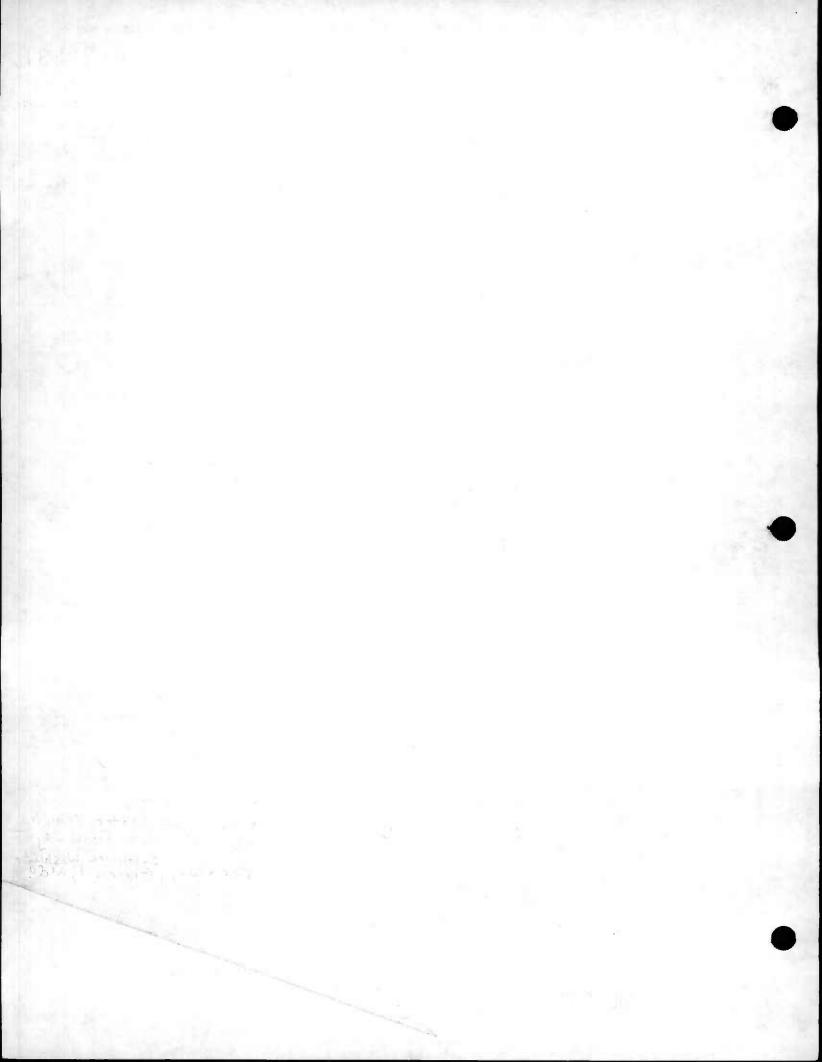
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State of Maryland / Department of Health and Mental Hygiene

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nue	11. Marital Status	12. Was Decedent E Armed Forces?		13. Was Decedent	of Hispanic Origin? (S Cuban, Mexicen, Puar	pecify Yes or No- to Rican, atc.)		 Americen Whita, etc 		
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any le	- James	owson, MD	. 21204							
14.	23a. Part1. Enter the disease, or cor shock, or heart failure. List only	mplications that caused to	the death. Do	not enter the mode of	dying, such as cerdia	c or respiratory arm	est,	A	pproximate terval Betwe	een
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	Immediate Cause (Final disease or condition	Multiple Injuries								
	Due to (or as a confequence of):									
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Sal	Causa (Diseasa or Injury that initiated events	c								
g	resulting in death) Last		ua to (or as a c	onsequance of):						
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Ca	Part II. Other significant conditions	contributing to death but	not resulting Ir	the underlying caus	a given in Part I	23b. Did tobacco use contribute to the ca			ne cause of	death?
Physician/			. Hot rodaning ii	, the underlying edec	givativities				bly 4□Ui	
by F										
8						24a. Was a perform			autopsy fin-	
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3e Completed	25. Was cese referred to medical			tpatient 3 DOA	Other: 4 Nursing H	Death (Check only one) g Home 5 ☐ Residence 6 ☐ Other (Specify)				
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State of Maryland / Department of Health and Mental Hygiene Kevin Antonio Booker-Brown

AMEND ITEMS: #23 PART I,27 ! PER MEO G78 Certificate of Death

22432

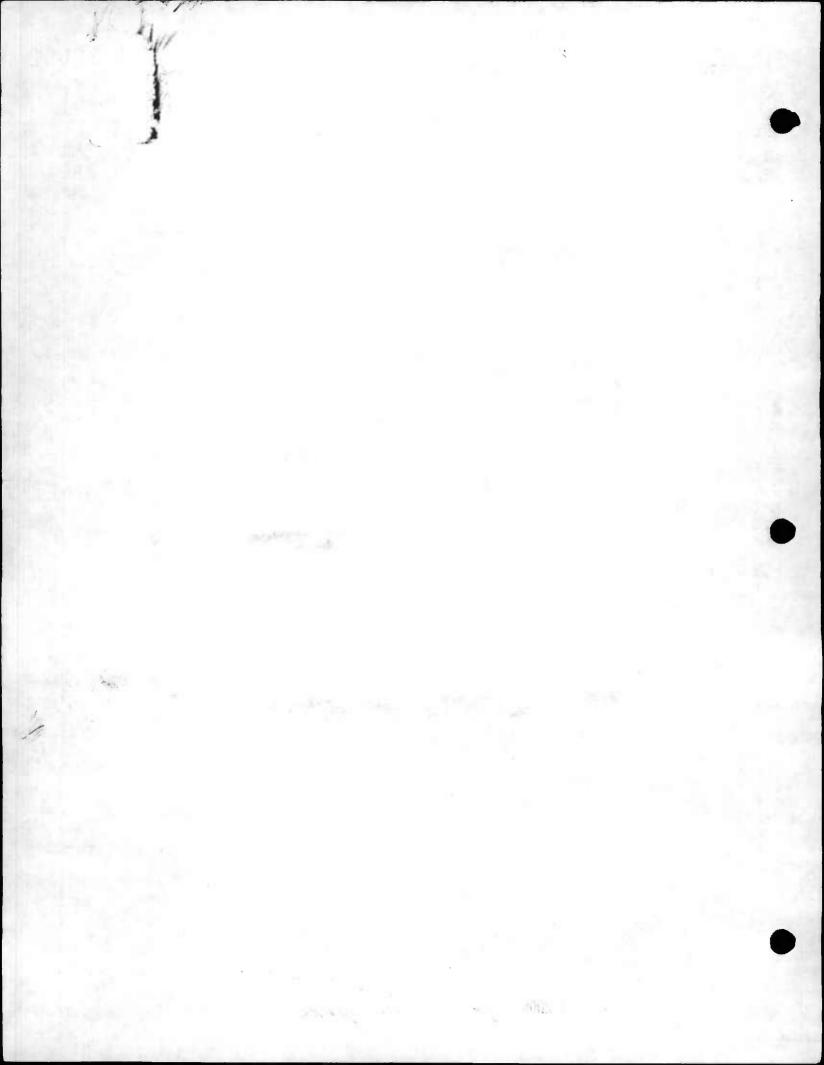
Physician /Medical Examiner
Funeral

The law requires that the death certificate be executed Box 68760. the (S) P.O. be det Division of Vital Records, page 2 or Attending Physician: this funeral After

1. Decedent's Nama (First, Middle, Last) 2. Date of Deeth 3. Time of Death Month July 2000 KEVIN A. BOOKER 11 11:44 A.M. 4c. County of Death 4b. City, Town, or Location of Death 4e Facility Name (If not institution, give street and number) Carroll County General Hospital Westminster Carroll If Under 1 Yeer | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex / 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days Months Hours 217-15-3769 Yrs. 06-09-81 MD Director Usual Residence of Decedent with the Marylend 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show ns 23a or 28a-f shor 1 ☐ Yes 2 ☑ No MD Funeral Director MILLS BALTIMORE OWINGS 10e. Street and Number 10f. Zlp Code 10g, Citizen of What Country? 20 BROOKBURY 21136 DRIVE USA Hems 14. Race - American Indian. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. other traumstic event, the Medical Examiner. Peges 1 and 2 should be filled within 72 hours after nent of Health and Mental Hygiene.
int: If item 27 is marked other than "natural", or ite 1 Yes 2 No If Yes, Give Year or Dates: 1 ■ Never Merried 2 Merried 1 Yes 2 No Specify: Maryland 21215-0020 Specify: BLACK p 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) STUDENT SCHOOL 8 TH GRADE NIA 17. Father's Name (First, Middle, Last) 18. Mothar's Name (First, Middle, Maiden Sumame) SHEILA GRAHAM ANTHONY BOOKER 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) BROOKBURY DR. OWINGS MILLS, MD 21136 SHEILA BOOKER MOTHER altimore, 20b. Place of Disposition (Nama of cemetery, crematory or other placa) 20c. Location - City or Town, State 20a. Mathod of Disposition permit. Pages
Department of h
important: If ite
eny injury or of
once. 1 ☑ Buriaf 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Othar (Specify) KING MEMORIAL PARK 7.15.00 RANDALISTOWN MD 21. Signature of Funeral Service Licansee 22. Neme end Address of Fecility VAUGHN C. GREENE FUNERAL SERVICE 23a Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or raspiratory arrest, about or healt failure. List only one cause on each line. 21229 Approximate Interval Between Onset and Death **Physician** DIABETIC KETOACIDOSIS AND LYMPHOCYTIC MYOCARDITIS Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Dua to (or as a consequence of) Examiner Sequentially list conditions, if any, laading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted evants rasulting in death) Last Due to (or as a consequence of): Physician/Medical Dua to (or as a consequence of): 23b. Did tobacco use contributs to the cause of death? Part It. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 1 Yes 2 No 3 Probably 4 Unknown þ 24b. Wara autopsy findings available prior to 24e. Was en autopsy Completed performed'i completion of cause of death? 1 Yes 20 No 1 Yes 2 No 25. Was case referred to medical axaminer? Be 26. Placa of Death (Check only one) Hospital: Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 9 Y Yes 2 No 1 ☐ Inpatiant 2 💆 ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending a Eunerel Director: Att Steely filled in by the full 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be datamined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Placa of Injury - At homa, farm, street, factory, offica building, atc. (Specify) 4 Homicide Hospital 1 Certifying Physician: To the bast of my knowledge, death occurred at the time, data and place, and due to the causa(s) and mannar as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, data and place, and due to the cause(s) end manner stated. 29a. Cartifian edicai To the Fune completely fi (Check only one) To the I within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E. July 12, 2000 30. Name and addrass of person who complated cause of death m 23a) (Type, Print) HEMONE MIKEL 111 Penn Street, Baltimore, Maryland 21201 32. Registrar's Signature 31. Data filed (Month, Day, Year) State JUL 17 2000 Registrar

DHMH 16 Rev 6/95



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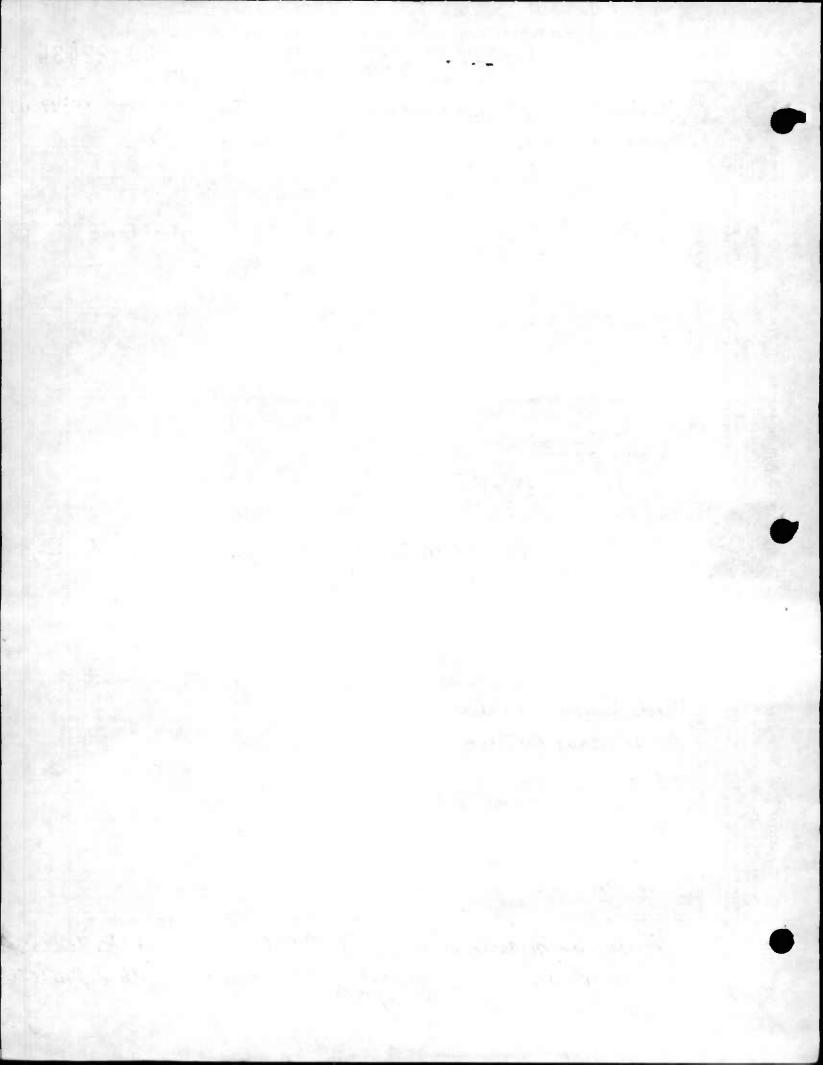
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Baltimore, permit. Pages 1 er Department of the Important: If then any injury or othe other.	4 Donetion 5 Other (Specify) 21 Signature of Funeral Service Licens	mo pres	R(SON) FORE R2 Name and Abdr	ges of facility W.	Jones Tre	BAITO	on Md F# PA md 2/229
Physician /Medical	23a. Part 1. Enter the disease, or compl shock, or heert failure. List only of Immediate Cause (Finel disease or condition	cations that caused the death. Do				st,	Approximate Intervel Between Onset and Death
8760, ate be executed thysician and the burial-transit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury	Cerebrova	scular e consequence of):	lism Accide	ent		2 hours 3 weeks
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E Sept D	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, building, etc. (Specify)			City or Town,	State)	or Rural Route Number,
To the Hospital within 24 hours To the Funeral completely filled Medical Co		sician: To the best of my knowledger: On the basis of examinetion eard manner stated.					
To the vithin : To the Comple	29b. Signature and title of certifier	0		se number		- 1	Month, Day, Year)
2N2/3	member	Attendingf	ysician De	50450	J	uly 10	, 2000
State Registrar	Patricia Greg	mbeted cause of death (II) m 23a MD 560	Lah Ru Jak	wen Blad	POB40=	Balhi	0, 2000 nave MDZ1239

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State of Maryland / Department of Health and Mental Hygiene 22434 Certificate of Death Reg. No 3. Time of Deeth 1. Decedent's Name (First, Middle, Last) 2. Date of Death Voer **Physician** 00:44 am 2. Wiam 08 2000 /Medical 4b. City, Town, or Location of Seath 4c. County of Death 4a Facility Name (If not institution, give street and number, Examiner Baldmore TOSE 5. Social Security Number If Under 24 Hrs. Hours Min. 8. Dete of Birth (Month, Dey, Year) If Under 1 Year B. Birthplace (Stete or Foreign Country) 7. Age (In yrs. last birthdey) **Funeral** X X 2 F Davs Months Yrs 45 214-64-4252 Director 2-12-54 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a, Stete 10b. County r than "natural", or itema 23a or 28a-f show the Medical Examiner must be notified at 1√ Yes 2 No MD Director NA Baltimore 10f. Zin Code 10g. Citizen of What Country? 10e Street and Number 450 N. Robinson Street 21224 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 12. Wes Decedent Ever in U.S. Armed Forces? 72 hours after 1 ☐ Yes 2 No If Yes, Give Yeer or Detes: 1 Never Married XX Merried Baltimore, Maryland 21215-0020 1 Yes 2000 Specify: Specify: þ 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry i filed within 73 i Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) pemit. Pages 1 and 2 should be filed w. Department of Health and Mental thygien important: If flem 27 is marked other the Chauffeur Baltimore City 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be William Nellie Bates Thompson 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Code) 19a. tnforment's Neme/Reletionship (Type, Print) 20b. Place of Disposition (Name of cemetery, cremetory or other place)

20c. Location - City or Town, State Dolores Bates 20a. Method of Disposition Burial 2 Cremation 3 Removal from State King Mem. Pk. Cem. 07-14-2000 Randallstown, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Neme and Address of Facility 21. Signature of Funerel Service Licensee Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest shock, or heart tailure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** /Medical tmmediate Cause (Final disease or condition resulting in deeth) Examiner Due to (or Examiner M attending physician and for use as the burial-transit Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760. certificate be Physician/Medical that initiated events resulting in deeth) Last Due to (or as e consequence of) Division of Vital Records, P.O. Part It. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 6 1 Yes 2 No 3 Probably 4 Onknown Houte Respiratory Failure þ 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed House Neval Farere has 1 Yes 2 PNo 1 ☐ Yes 2 20No 25. Was case referred to medical examiner? Be 26. Plece of Death (Check only one) 1 Yes 2 No Hospital: 1 Anpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 3 DOA 28a. Date of Injury (Month, Dey Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: of Attending Patter death.

I Director: After do in by the funer 1 Matural 5 Pending 1 Yes 2 No investigation 2 Accident 6 Could not be 3 Suicide 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or A within 24 hours after To the Funerel Dire completely filled in b 29a. Certifier 12 Certifying Physician: To the best of my knowledge, death occurred et the time, dete and place, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29c. License number 29d. Dete signed (Month, Dey, Year) 29b. Signeture end title of certifie eath (ttem 23a) (Type, Print) Korrile Mercu 62. Registrar's filed (Month, Day, Year) (
JUL 15 2000 State Registrar



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month **Physician** 2110 /Medical 4c. County of Digit 4a Facility Neme (If not institution, give street and number) Examiner A CIT THE HUSPITAL JUHNS TOPKINS 5. Social Security Number Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Days 1□ M 2 F Yrs. Director March 14,'25 227-30-9545 Virginia Usuel Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23s or 28s-f show with the Maryla Yas 2 No Director VA Richmond dical Examiner must be notifi-10f. Zip Code 10g. Citizen of What Country? 10e Street and Number Funeral 23220 1401 St. James Street, AptB. U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - Americen Indian, Bleck, White, etc. 12. Wes Decedent Ever in U,S Armed Forces? 11. Marital Status hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Nevar Married 2 Married 8 3altimore, Maryland 21215-0020 1 Yes 2 No Specify. Specify. P 3℃ Widowed 4 Divorced Black. Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within 72 pernit. Pages 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumetic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Nurse Aide Nursing/ Healthcare 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Meiden Surneme) Be moore Vorian Jesse Jackson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1401 St. James Street, Richmond, VA 23220 Jean Carey/ Niece 20b. Place of Disposition (Name of cematery, cremetory or other place) 20c. Location - City or Town, State Date 20e. Method of Disposition XXBurial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) 7/11/00 Oakwood Cemetery Richmond, VA (22. Nameland Address of Facility lass 21. Signature of Funaral Sarvice Licansee sf. Balto. aulton A.D. Price Funeral Est. 212 E. Leigh St.Rich.VA 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset and Death Physician /Medical Immediata Cause (Final disease or condition resulting In death) . HYPOXIC ENCEPHALOPATHY Examiner Examiner ASTHMATICUS The law requires that the death certificate be axecuted bunal-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Causa (Disease or Injury that Initiated events resulting in death) Last Due to (or as a consequence of): pue Box 68760, by Physician/Medical the Dua to (or as a consequanca of) Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Pert I. 23b. Did tobacco use contribute to the cause of death? P.O. 3 Probably 4 Unknown 1 Yes 2 No TIVE PULMONARY DISEASE Records, 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Medical Certification: To Be Completed completion of causa of death? After this certificate has 2 2 14 1 ☐ Yes 2 No of Vital 25. Was cese referred to medicet examiner? 26. Place of Death (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1. Inpatient 2 ER/Outpetient 3 DOA s after death.

I Director: After this od in by the funeral d 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how Injury occurred 27. Menner of Deeth 28c. Injury at Work? Division 1 Natural 2 Accident or Attending 5 Pending investigation 1 Yes 2 No 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Sulcida 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Hospital To Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the ceuse(s) end manner es steted.

2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, death occurred at the time, date end place, and due to the ceuse(s) and manner stated. 29a. Certifier completely (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and the of pertilled

State Registrar ANASTASIOS P. SAL 31. Date filed (Month, Day, Year)

JUL 1 7 2000

DHMH 16 Rev 6/95

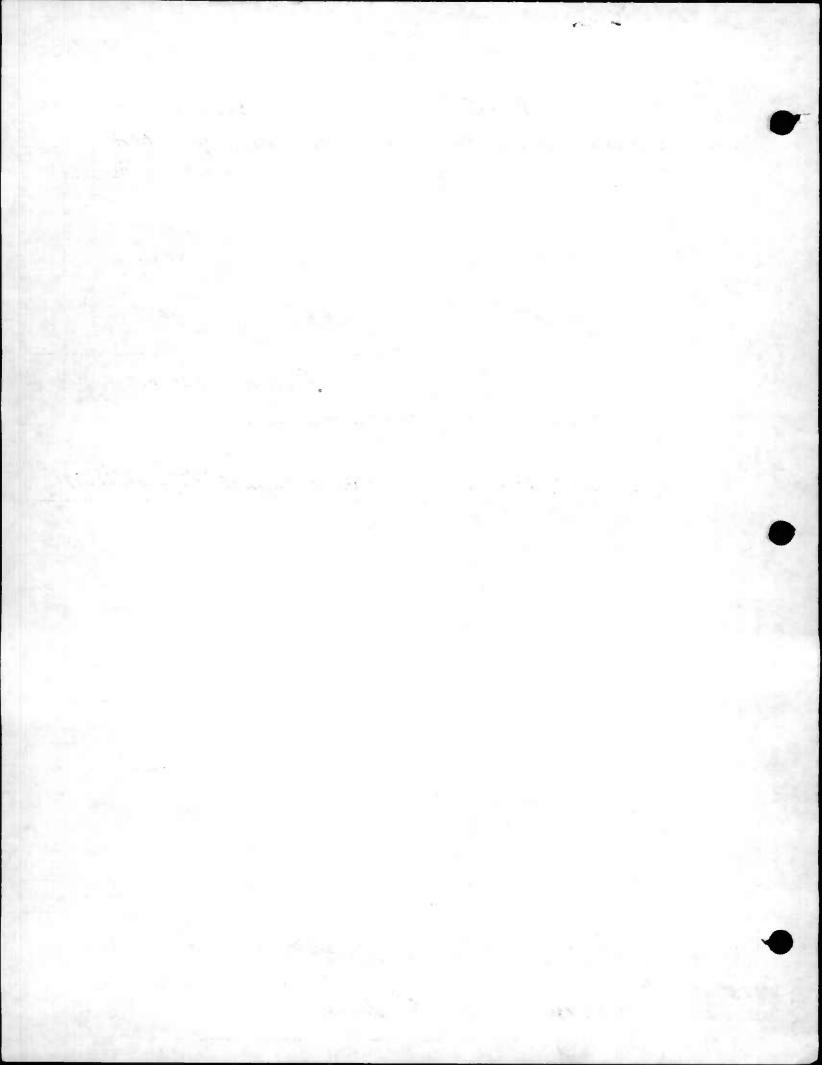
P. SALIARIS, JOHNS HOPKINS HOSPITAL, TOWER 110, BALTIMORE MD 21287

aliano

32. Registrar's Signature

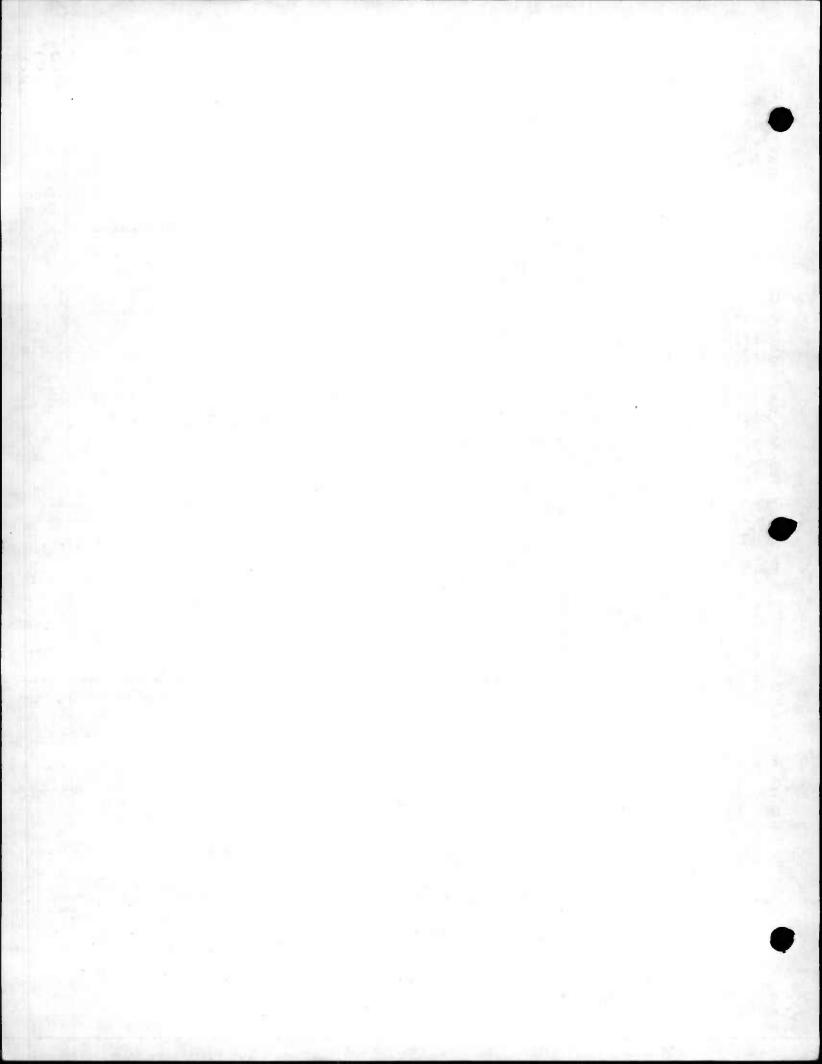
30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** HELEN A. CRAIG JULY 3:00AM 10, 2000 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner 2118 ROCKWELL AVENUE BALTIMORE BALTIMORE If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Dete of Birth (Month, Day, Year)
AUGUST 18,1914

9. Birthplace (State or Foreign Country)
PENNSYLVANIA 7. Age (In yrs. last birthday) **Funeral** Deys 1□M 21X F Yrs. 85 Director 178-07-3798 **Usual Residence of Decedent** the Meryland *out 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other than "natural", or flams 23a or 28a-f shor treumatic avent, the Medical Examiner must be notified at 1 ☐ Yes 2 ☑ No Director MARYLAND BALTIMORE BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 2118 ROCKWELL AVENUE 21228 UNITED STATES 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 230 No if Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indien. permit. Pages 1 and 2 should be filled within 72 hours effer of Department of Health and Mental Hygians. Important: if them 27 is marked other than "natural", or then any Injury or other treumatic ayent, the marked books. Bleck, White, etc. 1 Never Married 2 Married Saitimore. Marviand 21215-0020 1 Yes 2k No Specify: Specify: 3 Widowed 4 Divorced WHITE 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) BOOKKEEPER NATIONAL BISCUIT CO. 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Surneme) 8 GEORGE ANSELL MINNIE WORKS 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PAUL E. CRAIG / HUSBAND 2118 ROCKWELL AVENUE, BALTIMORE, MARYLAND 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other plece) 20c. Location - City or Town, Stete Dete 1 Burial 2 □ Cremation 3 □ Removel from State SCULLTON CEMETERY 07-14-00 SOMERSET, PENNSYLVANIA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Furtural Service Licer 22. Name end Address of Fecility N PARK FUNERAL HOME WILKENS AVENUE, BALTIMORE, MARYLAND 21229 767Bon Kerson 40 that caused the death. Do not enter the mode of dying, such as cardiec or respiretory arrest, cause on each line. 23a. Part1. Enter the disease, or complications shock, or heart failure. List only on Approximate Intervel Between Onset and Death , Physician Immediate Cause (Final disease or condition resulting in death) /Medical Examiner quence of): Physician/Medical Examiner cinous physicien and s the burlal-transit The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or as e consequence of) P.O. signed by the a Part It. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death?-1 Yaa 2 No 3 Probably 4 Unknown Records, by 24b. Were eutopsy findings available prior to completion of cause of deeth? Completed page 2 should 24a. Wes en eutopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No cartificata of Vital or Attending Physicien: director. 25. Was case referred to medical 8 26. Place of Deeth (Check only one) Other: 4 Nursing Home 5 Nesidence 6 Other (Specify) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA 1 ☐ Yes 2 No Certification: To the state After this funeral d 27. Manney of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of Division e Hospital or Attain. In 24 hours effer deeth. 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, ferm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 2 4 Homicide C To the Hospital or within 24 hours eff To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete end plece, end due to the cause(s) and menner as stated. 29a. Certifier Medical (Check only niner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title 29c. License number 29d. Date signed (Month, Dey, Year) 0005 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) sultimore, MD Gran 1 Year) 32. Registrar's Signeture State 2000 Registrar



00-3880-510

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

SYLVIA	
COTTMAN	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death

0	0	2	2	4	3	•
		1040	-		0	

	Physician
12	/Medical
	Examiner
100	

death with the Meryland

permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mentel Hygiene. Important: If Itam 27 is marked other than any injury or other terms.

or items 23s or 28s-f show

the Medical Examiner must be notified at

COTTMAN SYLVTA 4a Facility Nama (If not institution, giva street and number)

6. Sex

N/A

1□ M 21 F

Month JULY 4b. City, Town, or Location of Death

2. Data of Death

Day 13, 2000 6:33P.M. 4c. County of Death

N/A

Yaar

5. Social Security Number **Funeral** Director

Funeral Director

Be Completed by

213-32-5922 Usual Rasidence of Decedent 10a. State 10b. County MD

10c. City. Town or Location BALTIMORE

7. Age (In yrs. last birthday)

8. Data of Birth (Month, Day, Year) Hours APRIL 14 1936 Birthplaca (Stata or Foraign Country) MD 10d. Inside Cltv Limits

BLACK

Yes 2 No

3. Tima of Death

10e. Street and Number

11 Marital Status

1633 LORMAN COURT

1 Nevar Married 2 ☐ Married

3 Widowed 4 Divorced

1. Decedent's Name (First, Middle, Last)

1633 LORMAN COURT

10f. Zip Code 21217 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas?

Months

10g. Citizen of Whet Country? USA

Specify

14. Raca - Amarican Indian, Black, White, atc.

☐ Yas 21 No Yas, Giva Yaar or Datas: 15. Decedent's Education (Specify only highast grada completed)

1 Yas 27 No Specify: 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired)

16b. Kind of Business/Industry

Elementary/Secondary (0-12) 10

Collega (1-4or 5+)

Housewife

If Under 1 Yaar | If Undar 24 Hrs.

Days

Home

17. Fathar's Nama (First, Middle, Last)

CHARLES

COTTMAN

18. Mothar's Nama (First, Middle, Meiden Sumame)

19e. Informent's Neme/Relationship (Type, Print)

HELEN BOND

a Hypertensive Arteriosclerotic Cardiovascular Disease

19b. Mailing Addrass (Streat end Number or Rural Route Number, City or Town, Stete, Zip Code)

ROSA LEE MAKEL

/SISTER

20b. Place of Disposition (Nema of

1330 LAURENS ST. BALTO., MD. 21217 Data

20c Location - City or Town State

20a. Method of Disposition

1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from Stata 4 ☐ Donetion 5 ☐ Other (Specify)

cemetery, crematory or other place) MT ZION

7/18/2000 BALTO., MD.

Signature of Funaral Sarvice Licensee

23a. Perf. Inter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause in each line.

22. Name and Addrass of Facility
JAMES A. MORTON & SONS F.H., INC 1701 LAURENS ST. BALTO., MD. 21217

Physician /Medical Examiner

the burial-transit

deteched for use as

page 2 should be

peen

certificate hes

after death.

Director: After this certifica d in by the funerel director, i or Attending Physician:

To the Hospital or within 24 hours aft To the Funeral Di

filled in by

completely

pug

attending physician

The lew requires that the death certificate be executed

Box 68760,

P.O.

of Vital Records.

Division

Examiner

Completed by Physician/Medical

Certification: To Be

edicai

Sequentially list conditions, if any, leading to immadiata cause. Entar Underlying Cause (Disease or injury that initiated events rasulting in death) Last

Immediata Causa (Final disaasa or condition rasulting in death)

Dua to (or as a consaquanca of):

Due to (or as a consequence of):

Dua to (or as a consequance of)

Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part I.

23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown

24a. Was an autopsy INSPECTION

26. Place of Death (Check only ona)

24b. Were autopsy tindings available prior to completion of cause of death? 1 ☐ Yas 2 ☐ No

Approximata Interval Batween Onset end Deeth

25. Was casa raterred to medical axaminar? Yes 2□ No

28a. Data of Injury (Month, Day Year)

Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28b. Tima of Injury

Other: 4 Nursing Homa 5 Residence 6 Other (Specify) SCENE 28d. Dascribe how injury occurred

1 ☐ Yas 2 X No

27. Mennar of Death 2 Accident 3 Suicide

4 Homicida

5 Pending invastigation 6 Could not be datamined 28c. Injury at Work? 1 Yas 2 No

28f. Location (Streat and Number or Rural Routa Number, City or Town, Stata)

29a. Certifier (Check only one)

31. Data file

28e. Place of Injury - At home, farm, street, factory, office building, atc. (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and piece, and due to the cause(s) and mennar as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, and due to the cause(s) and mannar stated.

29b. Signatura and title of cartifian

29c. Licansa number O.C.M.E.

29d. Date signed (Month, Day, Year) JULY 14,2000

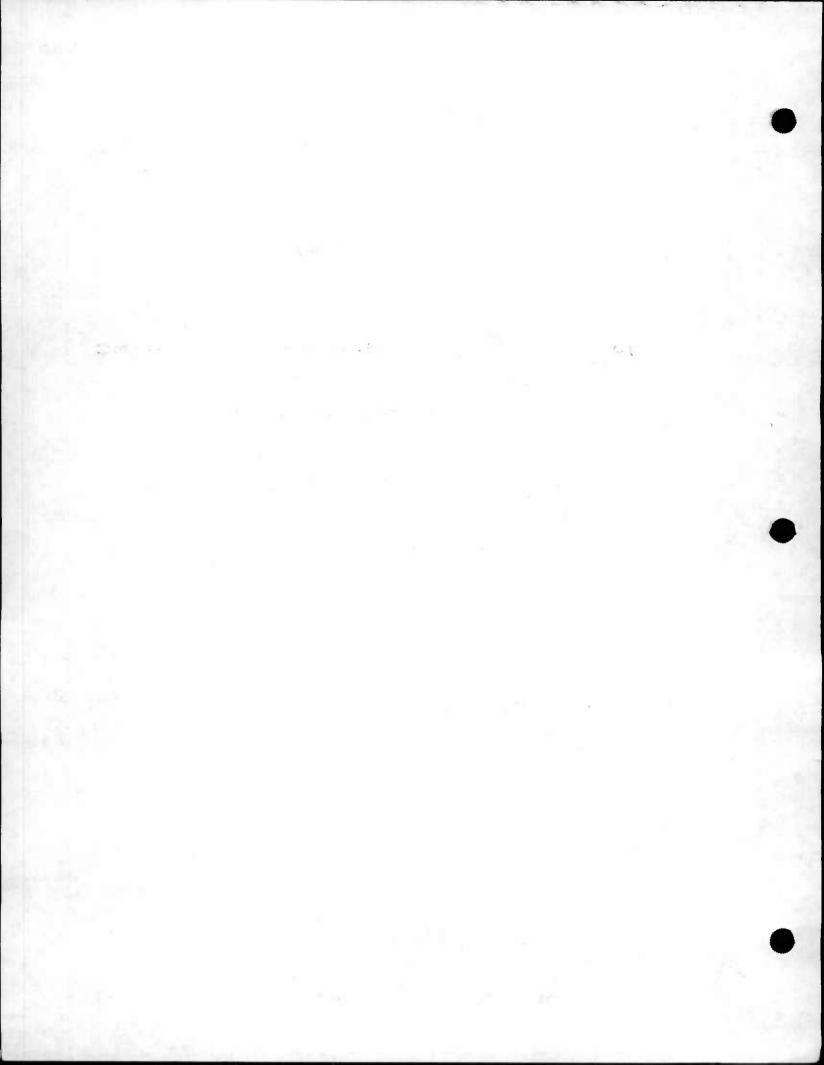
ss of person who complated cause of daath (Item 23a) (Type, Print) 30. Name and add JOSEPH

PESTANER M.D. 32. Redistrar's Signatura Penn Street, Baltimore, Maryland 21201

State Registrar

DHMH 16 Rev 6/95

CV



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Nama (First, Middla, Last) 2. Deta of Death 3. Time of Death **Physician** 12, **Eustace Evans Cramer** 2000 JULY 5:21AM /Medical 4a Facility Nama (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GREATER BALTIMORE MEDICAL CENTER BALTIMORE TOWSON Hours Min. 8. Date of Birth (Month, Day, March 8 5. Social Security Number If Under 1 Year 6. Sax 9. Birthplace (State or Foreign Country) New York 7. Aga (In yrs. last birthday) **Funeral** 15 M 20 F Months Days 092-18-7911 Director Usual Residance of Decedent 10a. Steta 10b County 10c. City. Town or Location 10d. inside City Limits 1 ☐ Yes 2 No Directo MD Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ 238 11532 Pebble Creek Drive 21093 USA Funeral 12. Was Decedant Evar in U,S.
Armed Forces?
1 X Yas 2 □ No
If Yas, Giva
Yaar or Datas: 141-146 natural, or hams 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Mexican, Puarto Rican, atc.) 11. Marital Status 14 Bace - American Indian Bleck, White, etc. 1 ☐ Nevar Married 2 1 Married 1 Yas 2 No Specify. 3 Specify: 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedant's Education (Specify only highast grada complated) 16b. Kind of Business/Industry Elamentary/Secondary (0-12) Collega (1-4or 5+) 12 Regional Sales Mgr. Black & Decker 17. Father's Name (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Surnama) Be Mental marked Morris Eugene Cramer Ella Bergstrom 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) Separtment of Health an important: If item 27 is B. Kelly Cramer/Son 202P Tall Oaks Dr., Weymouth, MASS 02190 Saltimore, 20b. Place of Disposition (Nama of cematary, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 7/14/00 1 ☑ Burial 2 ☐ Cramation 3 ☐ Removal from Stata Dulaney Valley Memorial Gardens Timonium, MD 4 Donation 5 □ Othar (Specify) 21. Signatura of Funeral Service Licer 22. Nama and Addrass of Facility Bryan W. Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 23a. Part1. Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximata Intervat Between Onset and Death **Physician** immediata Caus disaase or condition rasulting in death) /Medical Examiner ua to (or es a consequence of): HUMONIA Sequantially list conditions, if any, leading to immediata causa. Enter Underlying Cause (Disease or Injury that initiated avants rasulting in daeth) Last edicai Physician/M P.O. Part II. Other significant conditions contributing to death but not rasulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? signed by the 1 ☐ Y88 2 ☐ No 3M Probably 4 □ Unknown Records, þ 24b. Were autopsy findings aveilable prior to Be Completed 24a. Was en eutopsy performed? completion of cause of death? 1 ☐ Yes 2 No Division of Vital ai or Attending Physician: Ti s after death. Il Director: Atter this certificati ed in by the funeral director, ps 25. Was casa referred to medical axaminar? 26. Place of Death (Check only one) axaminar? Hospital: 1 hpatient 2 FP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 27. Mannar of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Metural 5 Panding invastigation 1 Yas 2 No 2 Accidant 6 Could not be datarmined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stete) 28e. Plece of Injury - At homa, farm, street, factory, office building, atc. (Specify) 4 Homicida n 24 hours aft e Funeral Di pletely filled in 29a. Cartifian Descritifying Physician: To tha best of my knowledge, deeth occurred at tha time, dete end place, and due to the cause(s) and menner as stated. Medical 2 Medical Examiner: On the basis of examinetion end/or invastigation, in my opinion, deeth occurred at the time, date and plece, and due to the cause(s) and menner steted. (Check only one) To the To the To the F 29b. Signatura and titla of certified 29c. License number 29d. Data signed (Month, Day, Year) 30. Name and addrass of person who completed causa of death (Item 23a) (Type, Print) 21204 W 6569 N. Charles St. Suite 601, Towson, MD Mitchell L. Schwartz, M.D.

DHMH 16 Rsv 6/95

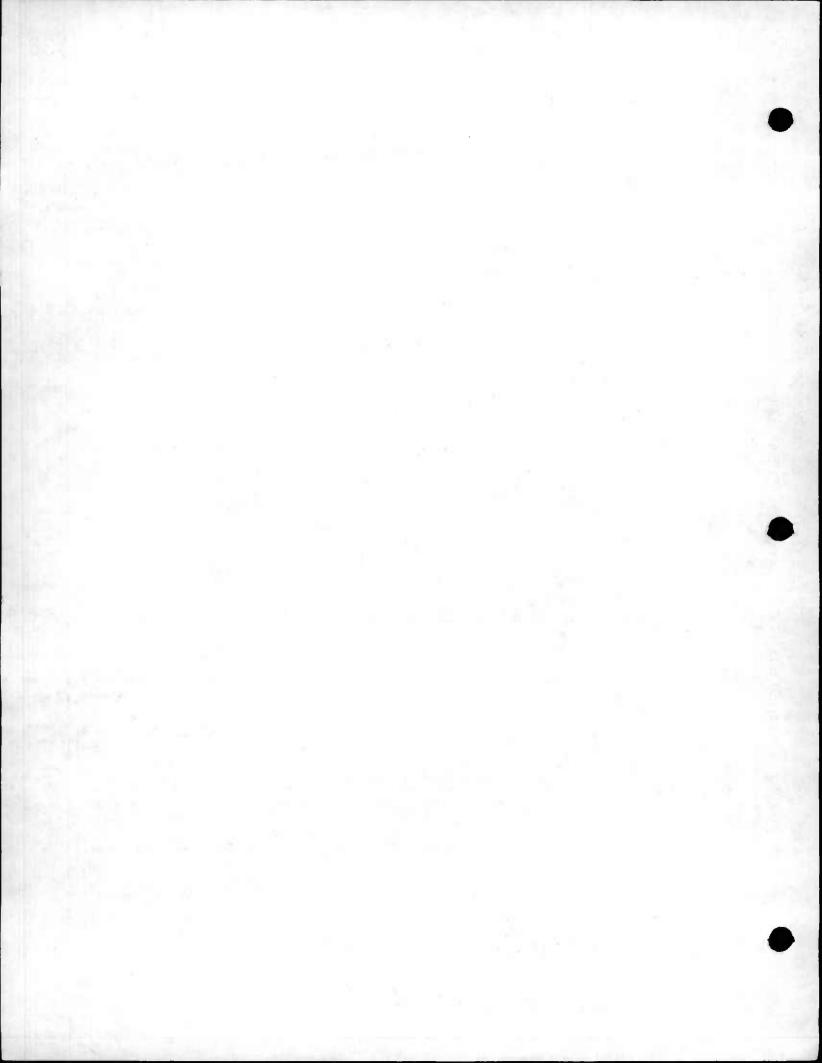
State Registrar

31. Data filed (Month, Day, Year)

Iramer

32. Registrar's Signatura

2000



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 1. Decedent's Neme (First, Middle, Last) **Physician** July Dorothea Hempel Chew 14. 6:04 A.M. /Medical 4b. City, Town, or Location of Deeth 4a Facility Name (If not institution, give street end number) 4c. County of Death Examiner Gilchrist Center Baltimore Co. Towson 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Dete of Birth Month, Dey, September 9. Birthplece (State or Foreign 7. Age (In vrs. last birthday) **Funeral** 27,1912 Baltimore, Maryland Months Days Hours 1 M 2 K F 87 215-24-3794 Director Usual Residence of Decedent 10d. Inside City Limits 10a State 10c. City, Town or Location 10h County 28a-f show the Medical Examiner must be notified at Maryland Worcester Co. Ocean City 1X Yes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 709 Boardwalk & Surf Ave. 21842 United States of America Nerns 23a 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Rican, etc.) Race - American Indian, Bleck, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give 1 Never Married 2 Merried 6 21215-0020 1 Yes 2 No Specify: Specify: White Completed by 3 Widowed 4 □ Divorced Year or Detes: 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiena. Elementery/Secondary (0-12) College (1-4or 5+) Book Keeper Building Construction 3altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumeme) Pages 1 and 2 should be in nent of Health and Mental Int: If Itam 27 Is marked or Christopher Hempel Nellie Werner 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Judy C. Boone(Daughter) 16 Kirsim Court Freeland, Maryland 21053 20b. Plece of Disposition (Name of cemetery, cremetory or other plece) 20c. Location - City or Town, State 20e. Method of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from Stete Department of important: If any injury or Hilltop Service Corporation 7/17/2000 4 ☐ Donetion 5 ☐ Other (Specify) Towson, Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. Service Licensee Jeffrey L. 1050 York Rd. Towson, Md. 21204 disease or complications that saused the deeth. Do not enter the mode of dying, such as cerdiac or respiratory errest, feilure. List only one cause on each line. **Physician** hemispheric stroke Immediate Cause (Finel disease or condition resulting in deeth) /Medical 8 months Examiner Physician/Medical Examiner requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest Due to (or es e consequence of): Due to (or as a consequence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? t Yes 2 No 3 Probably 4 Unknown þ écords. 24b. Were eutopsy findings evailable prior to completion of ceuse of death? 24e. Wes en autopsy performed? Completed After this certificate has page 1 Yes 1 ☐ Yes 2 ☐ No or Attanding Physician: funeral director, Medical Certification: To Be 25. Wes case referred to medical 28. Piace of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Dete of Injury (Month, Dey Year) 27. Menner of Death 28d. Describe how injury occurred Injury at Work? 5 Pending investigation 1 Netural 2 Accident after death. Director: Aft 1 ☐ Yes 2 ☐ No 3 Sulcide 6 Could not be 28e. Plece of Injury - At home, farm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete end plece, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, dete end plece, end due to the cause(s) and menner stated. 29e. Certifier 29d. Date signed (Month, Dey, Year) 29c. License number 29b. Signeture and title of certified 0 ons who completed cause of deeth (Item 33e) (Type, Print)

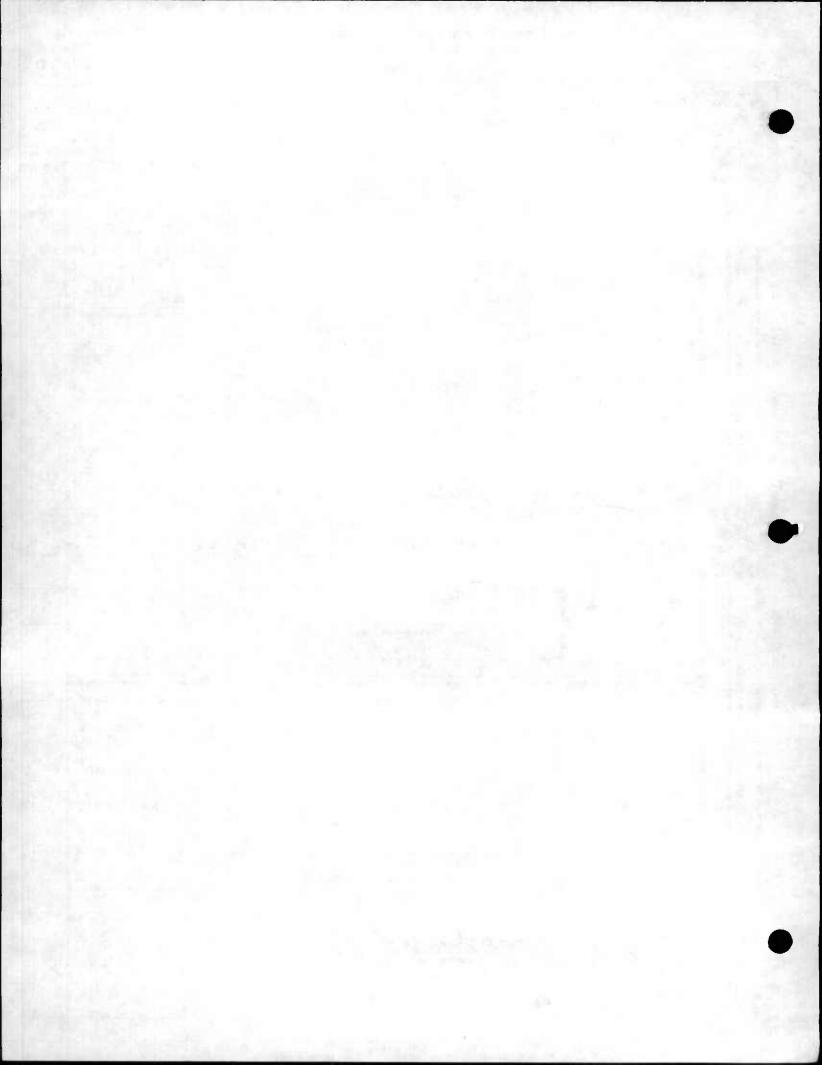
Registrar **DHMH 16 Rev 6/95**

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31. Dete filed (Month, Day, Year)

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32. Registrer's Signature



00-3746-510 Amended items 20b & per FD G786 8-21-00 WJJ Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. B.K.S State of Maryland / Department of Health and Mental Hygiene ANDRE CHAPET AMEND ITEMS: #23 PART I, 27 PER MEO G787 CERTIFICATE of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day 2000 Year **Physician** 8 Pay 1039 AM Andre Chaple , Sr. /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (If not institution, giva street and number) **Examiner** BALTIMORE NA JOHNS HOPKINS HOSPITAL E.R. If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Months Hours XX 2DF 41 213-70-1120 Director 03-28-59 MD Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits the Maryla 1 ☐ Yes 2 ☐ No Directo Baltimore 288-1 must be notifi 10f Zip Code 10g. Citizen of What Country? 10e. Street and Number tems 23a or 21205 2400 Madison Street Funeral 12. Was Decedent Evar in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Raca - American Indian, Black, White, etc. 1 Nevar Married & Married 1 Yes 2 □ No If Yes, Give Saltimore, Maryland 21215-0020 1 Yes 2√2 No Specify: Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Community Worker 10th Grade Part Time Baltimore City

18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) 86 Pages 1 and 2 should be nent of Health and Mental Annie Venable D. Chapple M. Frederick 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21205 19a. Informant's Name/Relationship (Type, Print) . 2400 E. Madison Street Baltimore, Maryland Katrina Chapple Department of Health mportant: If Item 27 20b. Placa of Disposition (Name of camatery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dumdalk, MD. Cem. 07-14-2000 Owing Mills 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Veshelli Menn Gardens st VA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licente 22. Name and Address of Facility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Parff. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximate Intervel Between Onset and Daeth **Physician** CARDIAC ARRHYTHMIA Immediate Cause (Final disease or condition rasulting in death) /Medical Examiner Due to (or as a consequenca of): FOCAL MYOCARDIAL FIBROSIS & ABNORMALITY "TUNNET" OF THE ANTERIOR LEFT CORONARY ARTERY The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events Due to (or as a consequence of) pug Box 68760 Due to for es a consequença of): phys P.O. Division of Vital Records. a or Attending Physics after death.

I Director: After this of in by the funaral di

Medical Certification: To Be Completed by Physician/Medical Examiner

Part II. Other significant conditions	d	sulting in the underlying	cause given in Pert I	23b. Did tobacco use c	ontribute to the cause of death
				1 ☐ Yes 2 ☐ No	. /
				24a. Wes en autopsy performed?	24b. Were autopsy findings available prior to completion of cause of deeth? 1 □ Yas 2 □ No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? NO Yes 2 No	Hospital:	☐ ER/Outpatient 3□ □	OOA Other: 4 Nursing	Home 5 ☐ Residence 6 ☐ Ot	her (Specify)
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3 Suicide 6 Could not l 4 Homicide determined		nome, farm, street, facto	ry, office	28f. Location (Streat and Num City or Town, Stete)	ber or Rural Route Number,
				ce, end due to the ceuse(s) end mourred at tha time, date and placa	
29b. Signathre and title of certifier		2:	9c. License number	29d. Date sign	ed (Month, Day, Year)

Registrar

filled in by

To the Hospital within 24 hours a To the Funeral Completely filled

Backs 31. Date filed (Month, Day, Year) 15 2000

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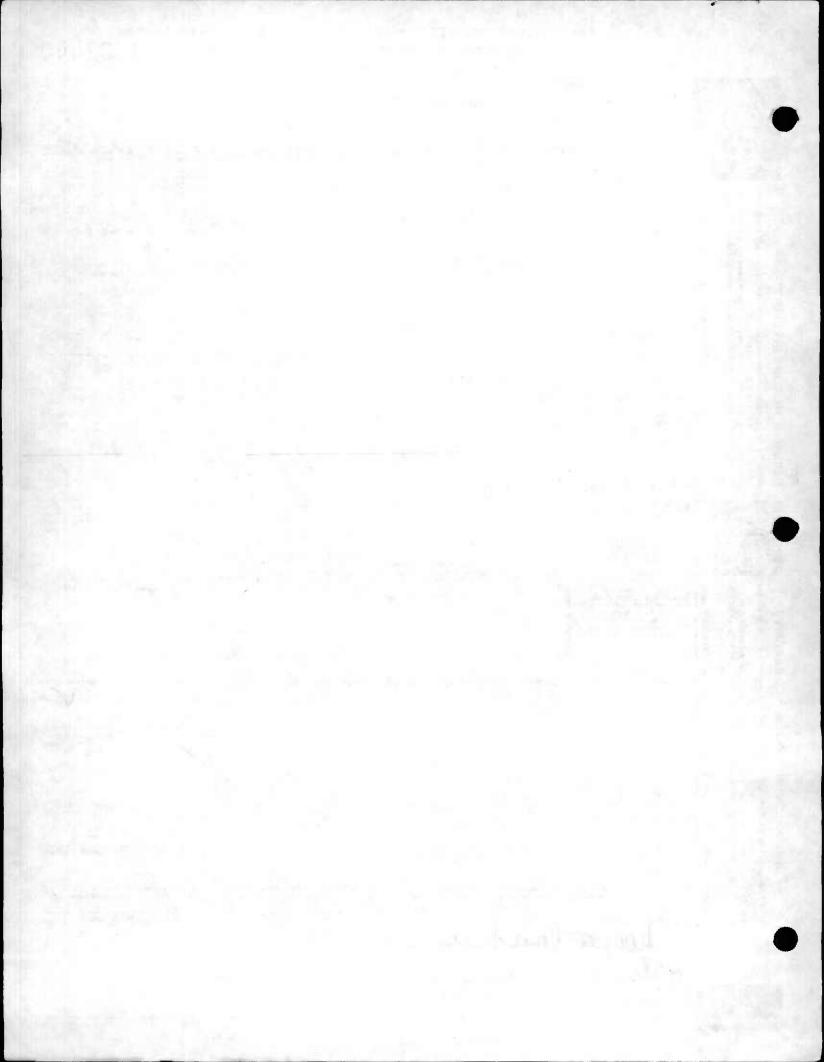
Korol 32. Registrar's Signatura

30, Name and address of person who completed cause of deeth (ftem 23a) (Type, Print)

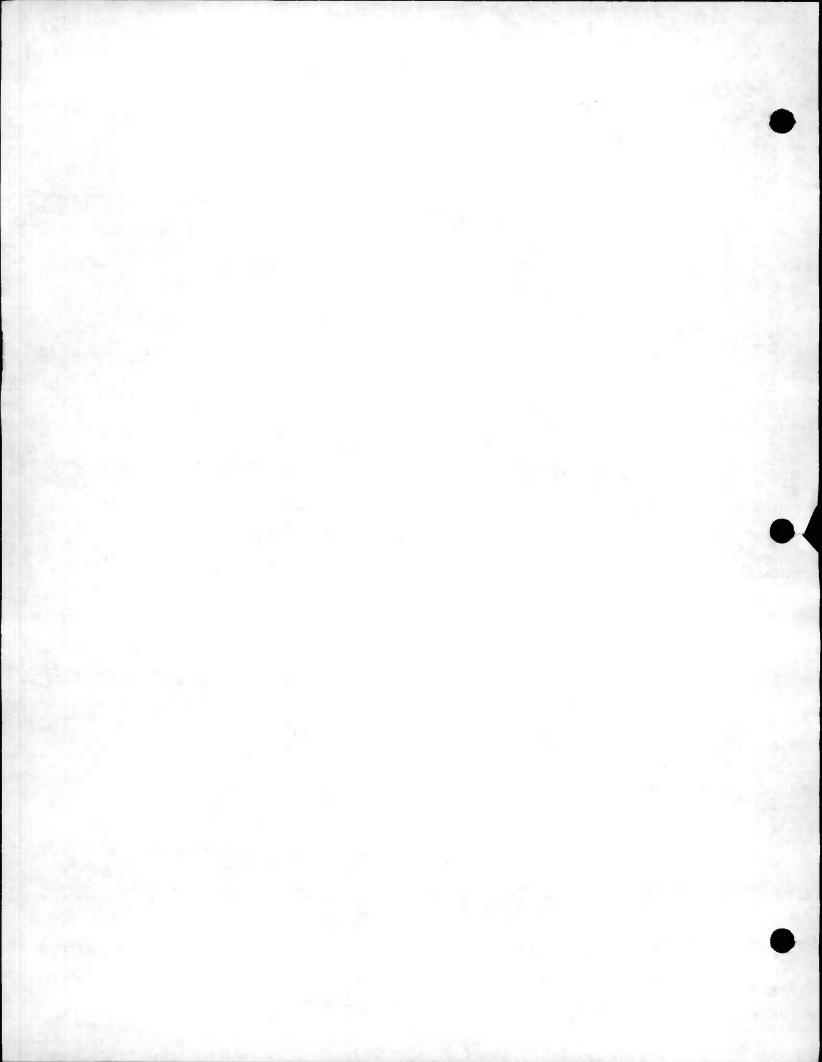
111 Penn Street, Baltimore, Maryland 21201

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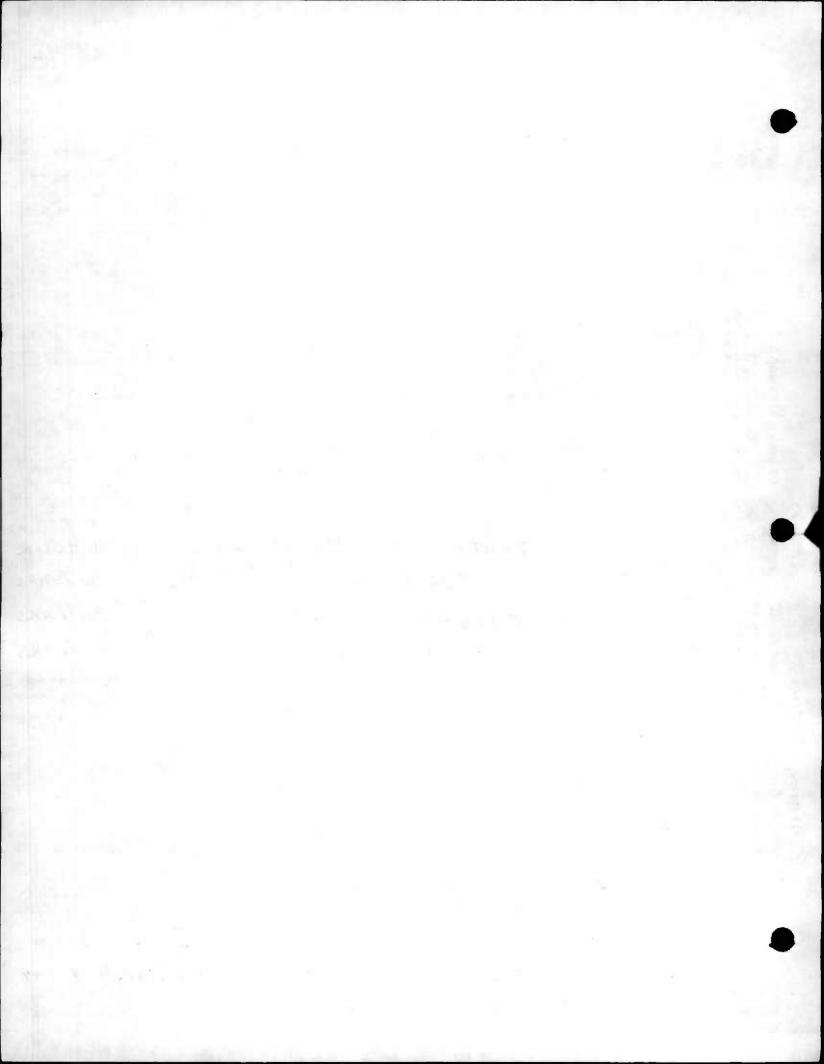


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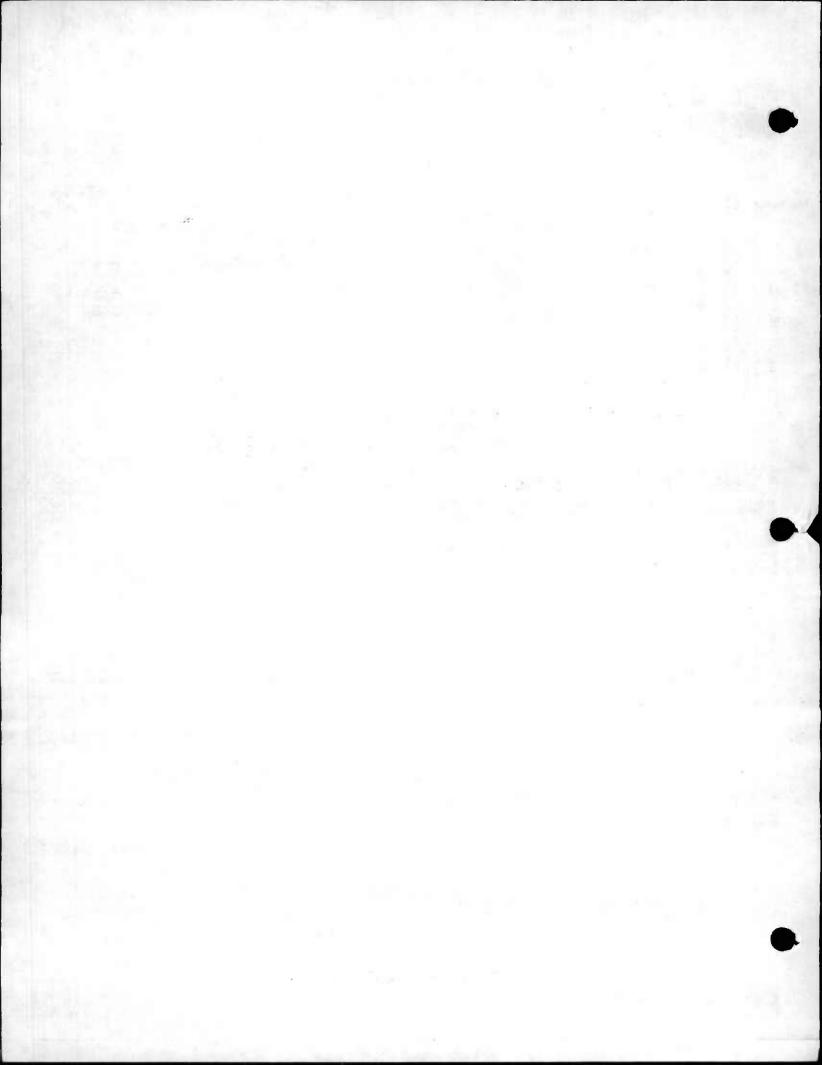


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		1 Decedent's New	ne (First, Middle, La	State of IVI		Certificate				2. Date of D	Reg. No.	U a	3. Time of Death	
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8	/Medical	EMMA S.		e street and number)				4b. City, Town	n or loc	JUL L	10	000 Coath	0801	
4	Examiner		n General	10 10 10 1				Fallst		Harford				
_		5. Social Security		-	ge (In yrs. last birt	hday) If Under	1 Year		-	8 Dete of Bi			lace (State or Foreign	
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	ier death with the Marylen flems 23s or 28s-1 show her must be notified as funeral Director	10e. Street and No 201 Day				10f. Zip	Code	de 10g. Citizen of What Country? USA					ntry?	
21215-0020	urs at	3 □ Widowed	ried 2⊠ Merried 4 □ Divorced	12. Wes Decedent Armed Forces? 1 Yes 2 If Yes, Give Year or Detes:		J.S. 13. Wes Decedent of Hispanic Origin? (Spif Yes, specify Cuban, Mexican, Puerto 1 □ Yes 2 ☒ No Specify:			in? (Spec Puerto R	cify Yes or N lican, etc.)	0- 14. Re Ble Specii	ce - Americ ock, White, by: W		
5	ed within 72 hours ygiene. or then "natural", ft, the Wedgel En-	(Soe	15. Decedent's Ed	Decedent's Usua (Give kind of wor	rk done	during most o	of workin	a i	16b. Kind of B	Business/Inc	dustry			
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la			lame/Reletionship (19b.	Mailing Address	(Street	end Number	or Rural	Route Numi	ber, City or Town	, Stete, Zip	Code)	
			General I	Hosptial		Milton Disposition (Nen		enue F	Falls	Dele	MD 2104			
Baitimore,		20a. Method of Dis 1 Durial 2 4 X Donation	20c. Location	- City or To	own, State									
Bai	Departm Departm Importar eny inju	21. Signature of Funcial Service Licensee Rohald State Director State Anatomy Board 655 W. Baltimore Baltimore, MD 21201												
		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory errest, Approximate Interval Between												
	Physician =						^						Onset and Death	
A.A.	/Medical Examiner	tmmediate Cause disease or conditi	on	Vent	rica	lar	H	rry	thi	mie			1 Houp	
1		resulting in death)			Due to (or es e	consequence of):		7	11		,		17	
_	P # P	1		DIYP	E2	DIAR	5-1	ES	Me	-11i	tis		30 YEARS	
	cate be executed physician and s the burlal-transit	Sequentially list of	onditions,		Due to (or es a c	onsequence of):		1					1./	
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ROX	death ce attendir ad for use siclan/			//								1		
oj.	the de y the a sched hysic	Pert II. Other signi	ficant conditions o	ontributing to death b	ut not resulting in	the underlying c	ause giv	ven in Pert I.		23b. Dtd	tobacco use co	ontribute to	the cause of death?	
7	es thet the death cer igned by the attendin be detached for use by Physician/N									1□	Yes 2 0	3 Prof	bably 4 Unknown	
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ב	After fune	⊘ Natural	5 Pending	28a. Dete of tnju (Month, Da		njury M	8c. Injui	rk? Yes 2 □ No		bu. Describe	how injury occu	neu		
Division	To the Mospital or Attanding Physicien: The is within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the funeral director, paga. Medical Certification: To Be Com	2 Accident 3 Suicide 4 Homicide	investigation 6 Could not be determined	28e. Plece of Inj	ury - At home, fer c. (Specify)			165 2014		28f. Location (Street end Number or Rurel Route Number, City or Town, State)				
	O See See													
	w Hospital n 24 hours w Funeral pietely filled edical C										cause(s) end m , date end plece	anner es si , and due to	tated. the ceuse(s)	
	within 2 To the comple								c. License number 29d. Date signed (Month, Dey, Year)					
		-	TAA			7	D 36715 July 11,200 ille Road Bel Air, Maryland 210					7000		
		30. Name and address of person who completed sause of death (Item 23a) (Type, Print)								~ UL	7 1 1,	2000		
		Showie	Osmai	11 1	3006	u soch	110	Ross	1.	Beli	fir Ma	rula	udamu	
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	Registrar	JUL	7 2000	beare	6	home	2							



	Certificate		Reg. No.	00 22443
Physician /Medical	1. Decedent's Name (First, Middle, Last) Napoleon Dortch	-		Year 10:55 PM
Examiner	4a Facility Neme (If not institution, give street end number) SHELLA MARIS VIIIA	TIMONIUN		ty of Death Himore
Funeral Director	5. Sociel Security Number 3.54-14-9655 1. DM 2. F 7. Age (In yrs. last birthday) Months Usuel Residence of Decedent	Year If Under 24 Hrs. 8 Days Hours Min.	Dete of Birth (Month, Day, Year) 7-15-16	9. Birthplaca (State or Foreign Country)
Marylend and show mad at	10a. State 10b. County 10c. City, Town or Location MARYLAND Baltonia	e	177	10d. Inside City Limits 1 ☑ Ves 2 ☐ No
O inter death with the Ma r terms 23a or 28e-1 s inter must be notified funeral Director	100. Street and Number 304 N. Arklington Ave 5	21223	10g. Citizen of	What Country? J S A
DO O O O O O O O O O O O O O O O O O O	11. Meritel Stetus 12. Was Decedent Ever in U,S. Armed-Forces? 1 \(\text{Never Merried} \) 2 \(\text{Married} \) Married 12. Was Decedent Ever in U,S. Armed-Forces? 13. Wes Decedent H Yes, specification of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the content of the	nt of Hispanic Origin? (Speci y Cuban, Mexican, Puerto Ri PNo Specify:	fy Yes or No- can, etc.) 14. Re Blo	oce - American Indien, ack, White, etc.
1 21215-0020 led within 72 hours et bygiene. her than "natural", or nt, the wind selection of Completed by F	15. Decedent's Education (Specify only highest grade completed) Elementery/Secondary (0-12) Coilege (1-4or 5+) MARG.	done during most of working retired)		Business/Industry O Carryout
be filed to the real Hygies of other perm, if	17. Father's Neme (First, Middle, Last)	18. Mother's Name (First, Middle, Maiden Surna	me)
Maryland 2 d 2 should be filed th and Mentel Hygi 7 is marked other traumatic event,	John Leu Dortch	Koxan	na Reed	
and 2 st ealth and n 27 is n	19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (MARIL 4n Charlewe Womble 1016 N.	Con Fral	Ave Bull	n, State, Zip Code) 01202
Baltimore, Maryland 212: permit. Pages 1 and 2 should be filed within Department of Health and Mentel Hygiene. Important: If Item 27 is merked other than any injury or other traumatic event, the Mades. To Be Comp	20e. Method of Disposition 20b. Place of Disposition (Name cemetery, grematory or oth	of		- City or Town, State
Balti pemit. Departri Importa any inju		Address of Fecility e's Meltopel	Han Chapel	AC Backs Not
O. Box 68760, ne death certificate be executed the attending physician and the for use as the burist-transit ysician/Medical Examiner	Immediate Ceuse (Finet disease or condition resulting in deeth) Bue to (or es a consequence of): Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Lest LUNG CANCER Due to (or es a consequence of): Due to (or es e consequence of):			
Cords, P.O. Box v requires that the death cert been signed by the attendin should be deteched for usa letted by Physiclan/M	d	use given in Pert f.		ontribute to the cause of death?
The lew requires that the law requires that page 2 should be de Completed by F			24a. Wes en autopsy performed?	24b. Were eutopsy findings eveilable prior to completion of cause of death?
The lew ate has I page 2 s	and the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of th		1□ Yes 2√ No	1 Yes 2 No
Vital Ficien: The certificate rector, pag	25. Wes case referred to medical examiner?	26. Place of Deeth (
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The lew requires that the death cerwithin 24 hours efter death. To the Funeral Director: After this certificate has been signed by the attendin completely filled in by the funeral director, page 2 should be deteched for usa Medical Certification: To Be Completed by Physician/N	1 Inpatient 2 ER/Outpatient 3 DOA	c. Injury at Work?	d. Describe how injury occu	ther (Specify) HOSPICE urred nber or Rural Route Number,
he Hospital in 24 hours he Funeral pletely filled	29a. Certifier (Check only one) 1X Certifying Physician: To the best of my knowledge, deeth occurred et 2 Medicat Examiner: On the basis of examinetion and/or investigation, is and menner steted.			
To the within Posts of Comp	29b. Signature and title of certifier 29c.	License number		ned (Month, Day, Year)
OD.	30. Name and address of person who completed cause of death (flem 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RI	D. TIMONIUM,	MD 21093	134
State Registrar	31. Dete filed (Month, Day, Year) 32. Registrar's Signature			



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Neme (First, Middle, Last) 2. Dete of Death 3. Time of Death Month Dev Year **Physician** 18;23 DOMINIQUE FRICO 11 2000 JU /Medical 4b. City, Town, or Location of Death 4e Facility Neme (If not institution, give street and number) 4c. County of Deeth Examiner Hopkins BOUTHORE Hospital AN If Under 1 Year | If Under 24 Hrs. 8. Dete of Birth (Month, Day, Year) 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Birthpleca (Stete or Foreign Country) **Funeral** Months XXM 2 F Yrs. Director 199-70-1195 10 09-24-89 PA Usuel Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Funeral Director MD NA 28a-f Baltimore 10a, Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 129 N. Amity Street 21223 USA 12. Wes Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ☐ Yes 2√ No Yes, Give 1 Never Merried 2 ☐ Married 8 1 ☐ Yes XDXNo Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced Blac Year or Detes: Completed 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Pages 1 and 2 should be filed within 72 to nent of Health and Mental Hygiene. Int: If Nem 27 is marked other than "natu Elementery/Secondery (0-12) College (1-4or 5+) Student Elementary School 4th Grade 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Travis В. Derico LaTasha McCray 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) LaTasha 4741 Elison Avenue Baltimore, Maryland 21206 Department of Health Important: If Item 27 McCray 20b. Piece of Disposition (Name of cemetery, cremetory or other place) 20e. Method of Disposition Dete 20c. Location - City or Town, Stete Burial 2 Cremetion 3 Removal from State 4 Donation 5 Other (Specify) Edgewood Cemetery 07-19-2000 22. Name and Address of Facility Orlando, FL. 21 Sint of Funeral Service Licensee Baltimore, Maryland 21202 WM.C.March Un 1101 E. North FH Avenue Enter the disease, or complications that devised the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, thuck, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Death Physician /Medical Immediate Cause (Finel DURN OMDILLA disease or condition resulting in deeth) Examiner CENTIFICATION IMPROVED BY MEDICAL the burial-trar Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Couse (Diseese or injury that initiated events resulting in deeth) Last Due to (or as a consequence of): Physician/Medical Due to (or es e consequence of). for use as I Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert i. 23b. Did tobacco use contribute to the cause of death? i signed by ti 1 Yee 20 No 3 Probably 4 Unknown Be Completed by 24b. Were autopsy findings eveileble prior to completion of cause of death? 24e. Wes en eutopsy performed? peeu 1 XYes 2 No 1 ☐ Yes 200 No director, 25. Wes case referred to medical 26. Placa of Deeth (Check only one) examiner? 1 △ Yes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 28a. Dete of injury (Month, Dey Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Menner of Death 28b. Time of 1. Naturel 5 Pending 1 Yes 2 No House FIRE 2 Accident investigetion June 10,2000 04:20

The law requires that the deeth certificate be executed P.O. Box 68760, Division of Vital Records, Attending Physician:

and

certificate

this

After

death.

North

hours after

altimore, Maryland 21215-0020

To the Hospital or Attendit within 24 hours efter death. To the Funeral Director: At completely filled in by the fu Medical State

ing

6 Could not be determined

3 Suicide

29e. Certifier (Check only one)

4 ☐ Homicide

29b. Signeture end title of certifier

28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify)

HOME

29c. License number RES-000

1 Certifying Physician: To the best of my knowledge, death occurred et the time, date and place, end due to the cause(s) end menner as stated.

2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) end menner stated.

ST.

29d. Date signed (Month, Dey, Year)

30. Name end eddress of person who completed cause of death (Item 23a) (Type, Print)

WOLFE ALEN KUING 600 N

BALTIMURE, MD 21287

28f. Location (Street end Number or Rural Route Number, City or Town, State)

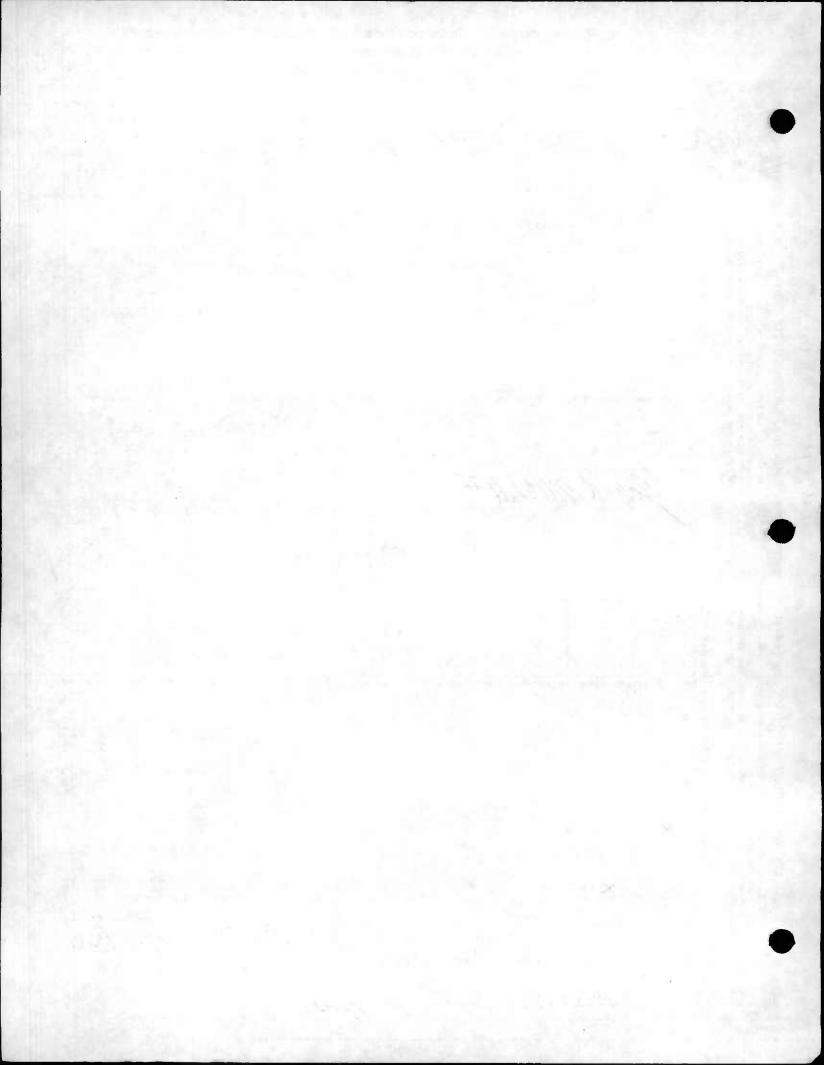
129 N. Amity St. BAltimore, MD.

Registrar

State of Maryland / Department of Health and Mental Hygiene 00 221.1.5

											Reg. No.		
Physician		George Fa								2. Dete of De Month Jul	Dey	Yeer 2 0 0 0	3. Time of Death
/Medical Examiner	4e Facility Neme	(If not institution, giver Balti	ve street end nu		1 Cen	ter	-	tb. City, Tov		cation of Deat	h 4c. Coun	ty of Deeth	
Funeral Director	5. Social Security 215-01-9	9809	Sex 12XM 2□F	7. Age (In yr 83	rs. last birthday Yrs.) If Under Months	1 Yeer Deys	If Under : Hours	24 Hrs. Min.	8. Dete of Bir (Month, De December	- 1	9. Birth	place (Stata or Forai intry) Iaryland
f show	Usuel Residence 10a. Stete Maryland	10b. County	ore	10c. City, Town or Location Baltimore									10d. Inside City Limi
r tems 23s or 28s-f showning the motified at Funeral Director	10e. Street and N 7110 She	lumber effield Rd				101. Zip Code 21212					10g. Citizen of What Country? United States		
or he	3 Widowed	arried 2 Merried 4 Divorced	Armed Fo	12. Wes Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yas, Give Year or Detes: 13. Wes Decedent of Hispenic Origin? (Sp. If Yes, specify Cuben, Mexican, Puarlo 1 ☐ Yes 2 ☑ No Specify:				ecify Yes or No Rican, atc.)	Spec	ack, White	lcan Indien, , etc. ite		
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Fastle, William



Please Type or Print in Biack Indelible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22446 Certificate of Death Reg. No. 2. Data of Death 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Day Month 10 ,2000 11:24 A.M JU14 YOLANDA J. FUSCO 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death Balti more Kosedale Center | Hunder 1 Yaer Franklin Square HOSPita Hours Min. 8. Date of Birth (Month, Day, Nov 21, Birthplaca (Stata or Foreign Country) NY 5. Sociel Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1□ M 2\ F Months 079-12-2091 84 Usual Rasidance of Dacedant 10a Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits 1 Yas 2X No Baltimore **Baltimore** 10e Street and Number 10g. Citizen of Whet Country? 10f. Zip Coda 1000 Franklin Avenue #906 21221 USA 14. Race - Amarican Indian, Black, White, etc. 12. Was Decedent Evar in U.S. Armed Forcas? 13. Was Decadant of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 11 Meritel Stetus 1 Yes 2 No If Yas, Giva Yaer or Detes: 1 Nevar Married 2 Married 1 Yas 2 No Specify: Specify: white 3 Wildowed 4 Divorced 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b. Kind of Businass/Industry Elementary/Secondery (0-12) Collega (1-4or 5+) 8 0 seamstress garment 17. Fathar's Nama (First, Middla, Last) 18. Mother's Neme (First, Middla, Maidan Surnama) Pasquale Porzio Concetta Paradisio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 9000 Franklin Square Dr Franklin Square Hospital Baltimore, MD 20b. Place of Disposition (Nama of 20a. Mathod of Disposition 20c. Location - City or Town, Steta Data cemetery, crematory or othar placa) 1 ☐ Burial 2 ☐ Cramation 3 ☐ Ramoval from Stata 4 ☑ Donation 5 ☐ Othar (Specify) Signature of Euperal Service Licensee Ronald S. Wade, 22 Nama and Addrass of Fecility State Anatomy Board 655 W. Baltimore Street Director 21201 Baltimore, MD 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiretory arrest, shock, or heart failure. List only one ceuse on each line. tmmediata Cause (Final diseasa or condition rasulting in deeth) . Intracranial 3 Hours Dua to (or as a consequence of): pertension Dua to (or as a consequence of) Dua to (or as a consequence of): 23b. Did tobacco usa contribute to the cause of death? 1 Yes 2 KNo 3 Probably 4 Unknown 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Physician /Medical Examiner

the

US9 68 1

The lew requires that the death certificate be executed

Box 68760,

P.0.

Records,

Division of Vital

Physician:

or Attending

After this funeral

the

filled in by

after death.

To the Hospital o within 24 hours af To the Funeral D completely filled i

Physician

/Medical

Examiner

Director

Funeral

Completed

89

2

MD

Funeral

Director

or litera 23a or 28e-f

filed within 72 hours after

Hygiene.

pemit. Pages 1 and 2 should be legariment of Health and Mental important: If Item 27 is marked or

Maryland 21215-0020

Saltimore,

USco,

Examiner Sequantially list conditions, if eny, laading to immediata ceusa. Enter Underlying Cause (Disease or injury that initieted evants rasulting in death) Last Be Completed by Physician/Medical

25. Was casa referred to medical axeminer?

5 Panding investigation

6 Could not be datarmined

1 Yas 2 No

27. Mennar of Death

1 Natural

2 Accident

3 Suicide

4 Homicida

Part II. Other significant conditions contributing to death but not resulting In the underlying cause given in Pert I. Coronary Artery Disease With Coronary Artery By Pass Graft

Hospital:

28a. Data of Injury (Month, Day Year)

1 Yas 2 KNo 26. Plece of Deeth (Chack only ona)

1 ☐ Yas 2 ☐ No

Othar: 4 Nursing Home 5 Residence 6 Othar (Specify) 28d. Describe how injury occurred

29a. Cartifier

edical Certification: To

To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and mannar as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and plece, and due to the cause(s) and mannar stated.

28c. Injury at Work?

1 Yas 2 No

29b. Signature and title of certifier

29c. Licansa number 2034

29d. Data signed (Month, Day, Yaar)

28f. Location (Street and Number or Rural Routa Number, City or Town, Steta)

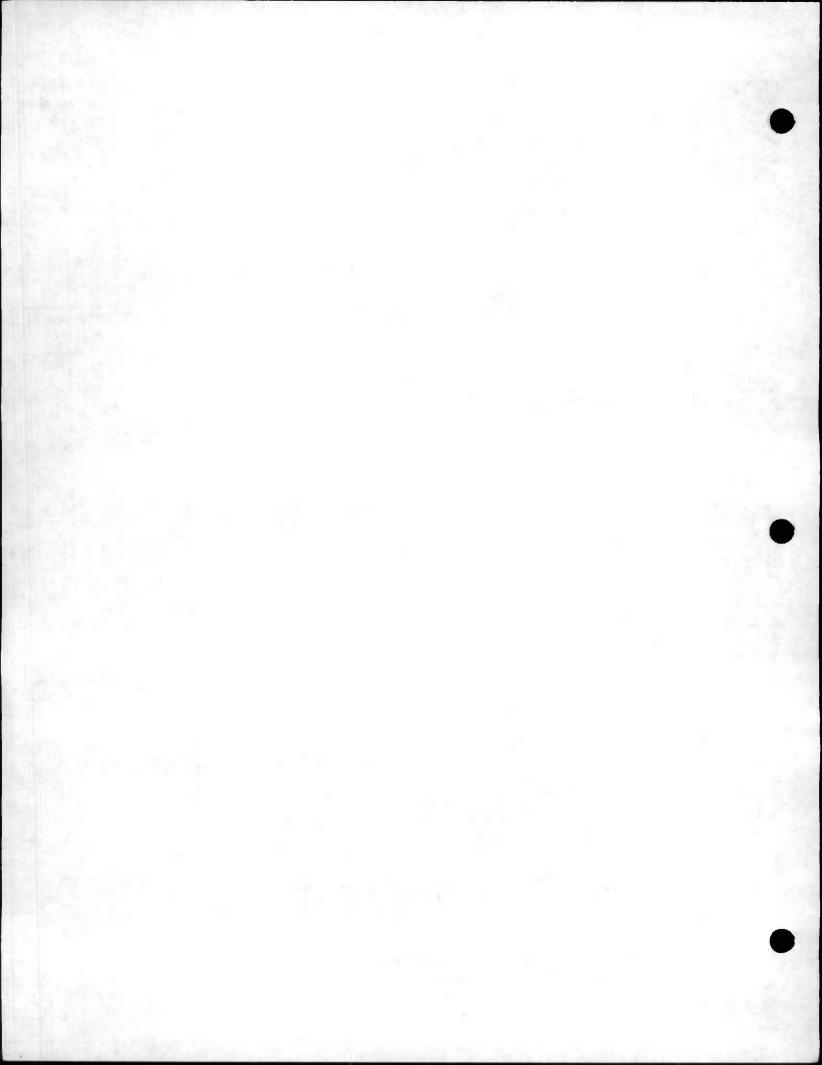
30. Name and address of person who completed cause of death (Itam 23a) (Type, Print)

9000 Franklin Square Drive Baltimore, MD Dr. Yvonne Latimer 31. Date filed (Month, Day, Year) 32. Registrar's Signature

State Registrar 2 ER/Outpatient 3 DOA

28b. Tima of

28a. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)



Physician

/Medical

Examiner

Funeral

Director

20 20 attac death	if, or terms 2 Examiner mus by Funera	11. Meritel Stetus 1 Never Merried 2 Married 3 Widowed 4 Divorced	12. Wes Decedent Examed Forces? 1 Yes 2 Not If Yes, Give		If Yes, s	cedent of Hispenic opecify Cuban, Mexico	fy Yes or No- can, etc.)		e - American Indi k, White, etc.		
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Ore Maryla	27 is marked traumatic a	19e. Informent's Neme/Reletionship			19b. Meiling Address (Street end Number or Rurel Route Number, City or Town, Sta B.A.R.C. 7215 York Rd., Towson, Md. 2						
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//	ysician Medical aminer	23a. Part Enterine disease, or con shock, or have feiture. List only Immediate Ceuse (Final disease or condition resulting in deeth)	one ceuse on each line).	not enter the m	ode of dying, such	as cerdiac or	respiratory arres		Approintervionset	
Division of Vital Records, P.O. Box 68760, or Attending Physician: The law requires that the death certificate be executed	been signed by the attending physician and should be detached for use as the burial-transit leted by Physician/Medical Examiner										
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] Inthe Hospital	Funer Funer stely fill	29e. Certifier 1 Certifying Pl (Check only 2 Medical Example)	hysician: To the best of miner: On the basis of e and menner stete	examinetion e	ge, deeth occurre and/or investigeti	ed at the time, date on, in my opinion, o	end place, en leeth occurred	d due to the cau d at the time, det	se(s) and me e end piece, s	nner es steted. and due to the ce	
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1. Decedent's Neme (First, Middle, Last)

5. Sociel Security Number

Usuel Residence of Decedent

213-36-7948

10e. Street and Number

Md.

10a. Stete

Director

4e Fscility Neme (If not institution, give street end number)

10b. County

Baltimore

8419 Rocky Mt. Road

Alethea Anna Foreacre

Franklin Square Hospital

6. Sex

10 M 20 F

Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. 22447

2. Dete of Deeth

8. Dete of Birth (Month, Dey, Yeer) Oct. 30,1923

JULY

Oct.

4b. City, Town, or Location of Deeth

Rosedale

Dey

2000

4c. County of Deeth

10g. Citizen of Whet Country?

U.S.A.

20c. Location - City or Town, Stete

Rece - American Indien, Bleck, White, etc.

White

Baltimore

3. Time of Deeth

Birthplece (State or Foreign Country)
 Maryland

10d. Inside City Limits

1 Yes 2 No

705pm

5 ☐ Other (Speci	ify)	Lake View	w Me	m. Park J	uly	18,2000 Syke	esville,	Md.
Service Lice	headt	E	ekha	Address of Fecility rdt Tunera: Reisterste		Chapel Rd., Owings	2111 Mills, N	
diseese, or con feilure. List only	nplications that caused the y one ceuse on each line.	e deeth. Do not enier the	mode o	of dying, such as cerdia	c or r	espiratory arrest,	Approx interve Onset	rimete i Between end Deeth
Final	Du	o v cuSc u/a	e of):				6 I	Pays
ditions, nediete ying	b.Chronic	Atrial to (or es e consequence	F e of):	brillat	ic	20		
njury nst	d.	e to (or es e consequenc	e of):					
ant conditions	contributing to death but n	ot resulting in the underly	ying ceu	se given in Pert I.		23b. Did tobacco use con	ntribute to the ca	
						24e. Wes an eutopsy performed?	of death?	opsy findings prior to n of cause
MA							1 Yes	2)000
d to medical	Hospitel: 1 Popatient	2 ER/Outpetient 3	□ DOA	Other:		Check only one) 5 ☐ Residence 6 ☐ Oth	on (Consity)	
5 Pending investigetion	28a. Dete of Injury (Month, Dey Yo	28b. Time of	280	injury et Work? 1 Yes 2 No	-	d. Describe how injury occur		
6 Could not be		- At home, ferm, street, f Specify)	ectory, o	office	28	f. Location (Street end Numb City or Town, State)	per or Rural Route	Number,
Certifying Pl	hysician: To the best of m miner: On the basis of ex and menner steted	aminetion end/or investig	urred at petion, in	the time, date end plec my opinion, deeth occ	e, en	d due to the cause(s) and me at the time, dete end piece,	enner es steted. and due to the ce	use(s)
le di certifier			1	icense number		29d. Dete signe	d (Month, Dey, Ye	ear)
S of person who	completed cause of deetless 2000 f	reankin !	Soy	ane Pair	E	BALTIMORE 1	m 21	237
JUL 1	7 2000 Registrer's	repers 2	9	Spals				
		ORIGINA	L					

State Registrar 30. Neme and addre

JUDE 31. Dete filed (Month. State of Maryland / Department of Health and Mental Hygiene Certificate of Death

center

10f. Zip Code

21237

7. Age (In yrs. lest birthday) If Under 1 Year If Under 24 Hrs.

Months Deys Hours Min.

76

10c. City, Town or Location

Rosedale

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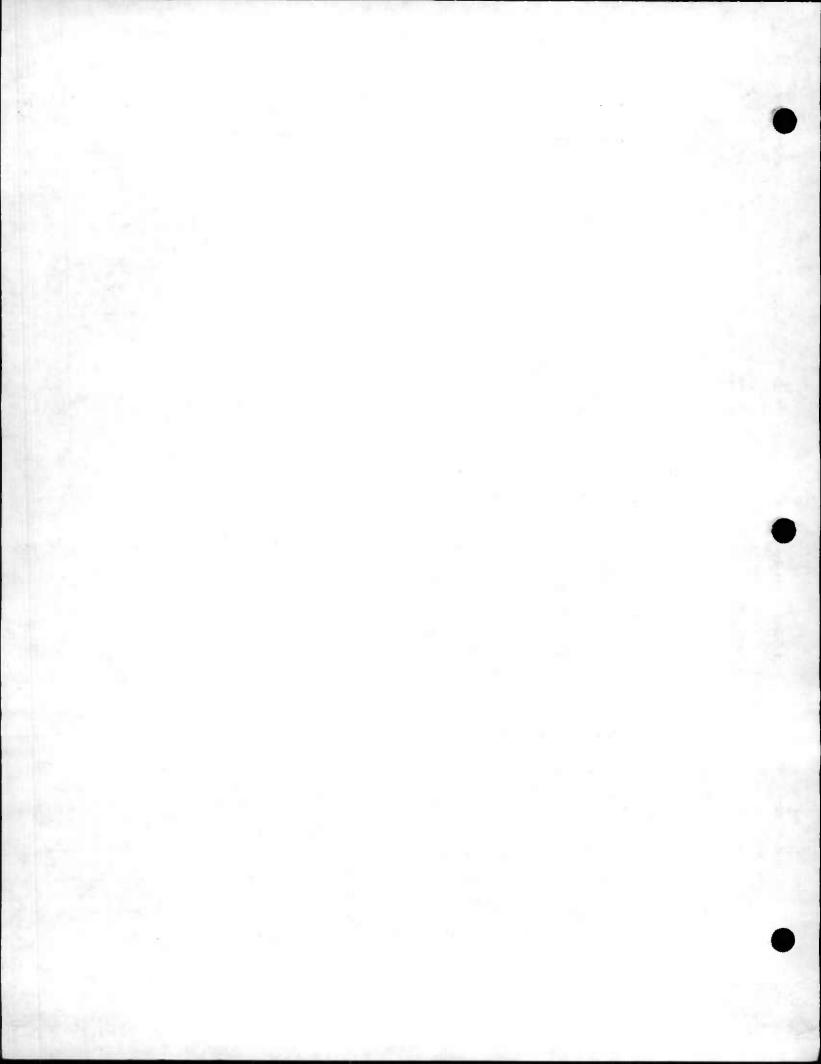
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	Decedent's Name (First, Middle, Las.	State of Mary	•	ertificate of			Reg. No.	3. Time of Death			
sician	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s	ILES				July July	Day	Year 14:33(PM			
ledical aminer	4a Facility Name (If not Institution, giva					or Location of Deat	,				
			ENTER			MORE	N/A				
eral tor	5. Social Security Number 6. Se 214-02-6639	ox 7. Age (In	73 Yrs.	Months Days	If Under 24 H	in. 8. Date of Bir (Month, Da Nov. 2	th Yeer) 5, 1926	9. Birthplace (State or Foreign Country) Maryland			
	10a. Stata 10b. County	10	c. City, Town or L	ocation			10d. Insida City Limite				
tor	MD Anne Arun	ide1	inthicur	n			1 ☐ Yes				
al Director	10e. Street and Number 620 Franklin Ave.			10f. Zip Coda 21090			10g. Citizen of What Country? U.S.A.				
by Funeral Director	11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U,S. 13.	Was Decedent of Hif Yes, specify Cubin 1 ☐ Yes 2 ♣No	lispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	14. Race Blace Specify	e - Americen Indian, k, While, etc. : White			
ed within 72 hours eiter death with the Maryland Vijelen. The than "natural", or items 23s or 28s-f show it, the Madical Examiner must be notified at Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad		edent's Usual Occup e kind of work dona DO NOT usa ratire	ation during most of	vorking	16b. Kind of Bu	sinass/Industry				
idmo	Etamantary/Secondary (0-12)	College (1-4or 5+)		ty Contro			Glass	Manufacturing			
end 2 should be file as the next and Mental H n 27 is marked out her traumatic ever To Be	17. Father's Name (First, Middle, Last) William J. Marti	n			18. Mother's N	lame (First, Middle E. Moyer	, Maiden Sumem	Θ)			
	19a. Informant's Name/Ralationship (T. Benton T. Giles	ype, Print)		ing Address (Street							
	20a, Mathod of Disposition 1 ⊠ Burial 2 □ Cremation 3 □ I 4 □ Donation 5 □ Other (Specify,		City or Town, Stete n Park, MD								
	21. Signatur of Funeral Strvice Licensee 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 21227										
	23a. Part1. Enter the disease, or comp shock, or haart faitura. List only o	lications that ceused the						Approximate Interval Between			
an cal	Immediata Causa (Final disease or condition			- INFI				Onset and Death			
ner 🚡	resulting in daath)	Due	to (or as a conse	equence of): .				15.			
dical Examiner		b. CORON	ARY P	RTERY	DISE	426		1 years			
Exa	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or trijury that Initiated events	506	I to (or as a conse	equence or).							
edical	that Initiated events resulting in death) Lest	C. Due	fo (or as a conse	quence of):							
Physician/Me	4.5	d									
sicl	Pert II. Other eignificant conditions co	ntributing to death but no	of resulting in the	underlying ceuse giv	ven in Part I.	23b. Did	tobacco uee co	ntribute to the cause of death?			
P.	1. RENAL	FAILURE	5			10	Yee 2 No	3 Probably 4 Unknown			
Completed by	2. HYPERTE	NSION					an autopsy ormed?	24b. Wara autopsy findings available prior to completion of cause			
dmo						10	Yes 200 No	of death?			
BeC	25. Was cesa raferred to medical			7	26. Place of I	Death (Check only		72100 222110			
0	axaminar? 1 ☐ Yes 2 ☐ No	Hospital:	2 ER/Outpatio	ent 3 DOA Oth	oer.	g Home 5 ☐ Ras		er (Specify)			
	27. Manne of Death 1 DNatural 5 Panding 2 Accident Investigation	28a. Data of Injury (Month, Dey Ye	28b. Time Injury	Wo	ryat rk? Yes 2 □ No	28d. Describa	how injury occur	red			
Certification: To	3 ☐ Suicide 6 ☐ Could not be datarmined	28e. Place of Injury - building, atc. (S	Af homa, farm, s specify)	treef, factory, office		28f. Location (City or To	Streat end Numb wn, Stete)	er or Rurel Route Number,			
edlcai (29a. Certifier Check only one) Certifying Phy	rsician: To the best of m Iner: On the basis of exa and manner stated	amination and/or i	th occurred at tha tin nvestigation, in my o	me, data and ple opinion, death o	ace, and dua to tha courred at the time,	cause(s) and ma data and place,	nner as stated. and dua to the cause(s)			
Medical Certifi	29b. Signature and talk of certifier	nindi li mali	WE CLO	29c. Licens			29d. Date signe	d (Month, Dey, Year)			
	I II - WINE	DICAL INTENS	IAC -LIE		P1314	0	JULY	14 2mm1			
2	30. Name end address of person who c	completed ceuse of death	(Itam 23a) (Type	o, Print)				14, 2001			
3	30. Name endeddress of person who co	completed ceuse of death	(Itam 23a) (Type	o, Print)				1 1			
State	30. Name enceddress of person who co SAMEER BAPE MD 31. Date filed (Month, Dey, Year)	sompleted ceuse of death 300 S 0 32. Registrar's	utt HAN	OVER STR	EET,			AND 21225			
State gistrar	30. Name endeddress of person who co	sompleted ceuse of death 300 S 0 32. Registrar's	utt HAN	Spark	EET,			1 1			

DHMH 16 Rev 6/95

ORIGINAL



State of Maryland / Department of Health and Mental Hygiene 22449 Certificate of Death 3. Tima of Death 1. Decedent's Nama (First, Middle, Last) 2. Data of Death Day **Physician** 605 pm 2014 14 2000 Laura /Medical Gedeon 4a Facility Name (If not institution, giva street and number) 4b. City, Town, or Location of Daath 4c. County of Death Examiner Franklin Square Hospital Rosedale Baltimore center If Under 1 Year | If Under 24 Hrs. | 8. Data of Birth | Months | Days | Hours | Min. | (Month, Day, Year) Birthplaca (State or Foreign Country) 5. Social Security Number 6. Sex 7. Aga (In yrs. lest birthday) **Funeral** Days 1□ M 25 F Director 212-30-0797 9/2/1932 Maryland 10a. Stata 10c. City, Town or Location 10b. County 10d. Insida City Limits rai", or itema 23a or 28a-f show Examiner must be notified at 1 ☐ Yas 2 ☐ No Director Maryland Baltimore Essex 10e. Street and Number 10g. Citizan of What Country? 10f. Zip Code "natural", or itema 23a or Funeral 227 Southeastern Court 21221 S. A 14. Raca - Amarican Indisn, Black, Whita, atc. 13. Was Decedent of Hispanic Origin? (Specify Yas or No-If Yas, specify Cuban, Maxican, Puarto Rican, atc.) 12. Was Decedent Evar in U,S. Armed Forcas? 11. Marital Status 1 Nevar Married 2 Married 1 Yas 2 No 1 ☐ Yas 2 No Specify: py Specify: 3 ☐ Widowed 4 □ Divorced White Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highest grade completed) Etamantary/Secondary (0-12) Collega (1-4or 5+) 8 Child Care Day Care Important: If item 27 is marked other any injury or other traumatic evant, the Maryland 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumeme) Be Peges 1 and 2 should be nent of Health and Mental P Lawrence Bures Frances Rites 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street end Number or Rural Routa Number, City or Town, State, Zip Code) Sharon Lee Butler (Daughter) 227 Southeastern Court Essex, MD 21221 altimore. 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stata 20a. Mathod of Disposition Date Department of Holly Hill Memorial Garden 1 XBurlal 2 ☐ Cremation 3 ☐ Ramoval from State 4 ☐ Donation 5 ☐ Othar (Specify) Gardens Middle River, MD 21. Signature of Funaçal Sarvice Licensee 22. Nama and Addrass of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Es 23a. Part 1. Enter the disease, or complications to a used the death. Do not anter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Essex, MD 21221 Approximata tntarval Batwean Onsat and Daath **Physician** /Medical Immediata Causa (Final a Metastasis disaasa or condition rasulting in daath) 4 years Examine Physician/Medical Examiner Breast sician and burial-transit Cancer the deeth certificate be assecuted Sequantially tist conditions, if any, laading to immediata causa. Entar Undarlying Cause (Disease or injury that initiated evants rasulting in death) Last Dua to (or as a consequence of) physician s the buria Box 68760. Dua to (or as a consequence of) 80 for usa P.O. Part II. Other algnificant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contributa to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown of Vital Records, Completed by The lew requires 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? hes page 2 1 ☐ Yas 2 ☐ No 1 Yas Be 25. Was casa rafarred to medical 26. Placa of Daath (Check only one) 1 Yas 2 Do Othar: 4 Nursing Homa 5 Rasidanca 8 Othar (Specify) Hospital: 1 Dippatiant edical Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Matural To the Hospital or Attending Pt within 24 hours efter death.
To the Funeral Director: After th complately filled in by the funera 28c. Injury at Work? 28d. Dascribe how injury occurred Division 5 Pending investigation Injury 1 Matural 1 Yas 2 No 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicida 28a. Placa of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homlcida The propertity of the post of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

In the post of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated.

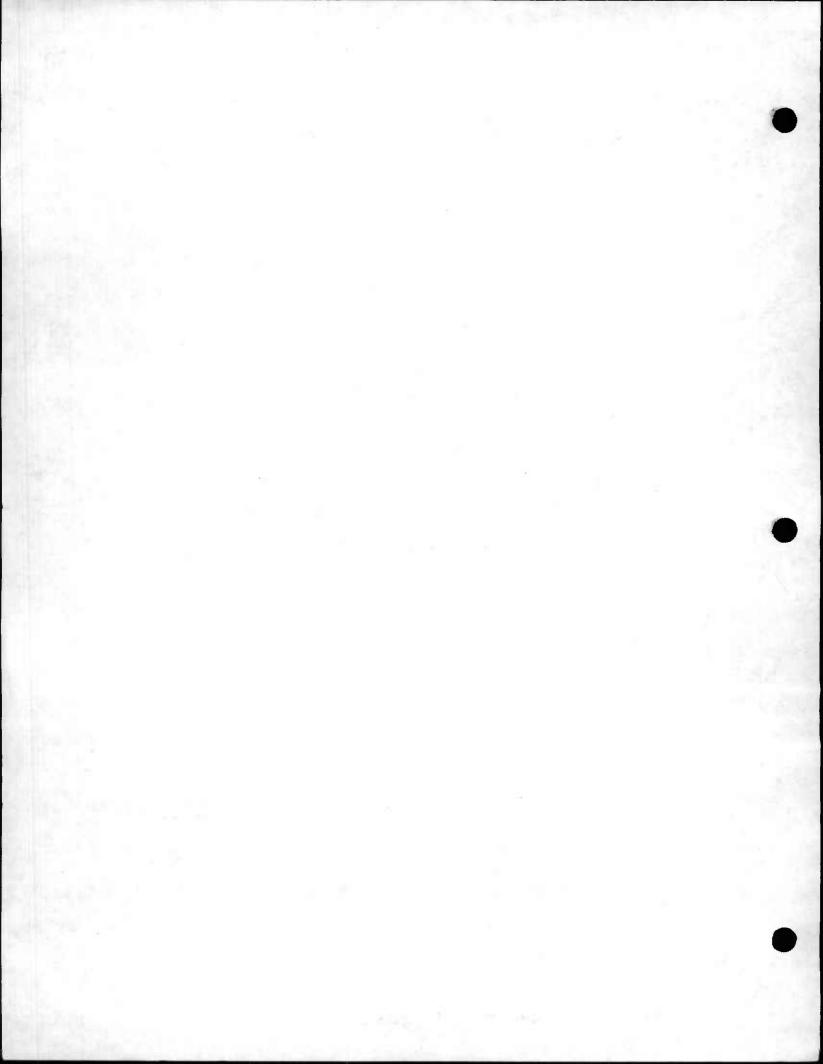
In the post of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. Licansa number 29d. Data signad (Month, Day, Year) 29b. Signature and title of certifier RD 203505 ROUVEY NE OF DOOR with complated causa of death (Item 23a) (Type, Print) 9000 Franklin Square Drive Baltimore Maryland 21237 DR Anna Izavierdo-Porrera 31. Data filed (Month, Dey, Year) 32. Pegistrar's Signature State JUL 17 2000 oaks Registrar

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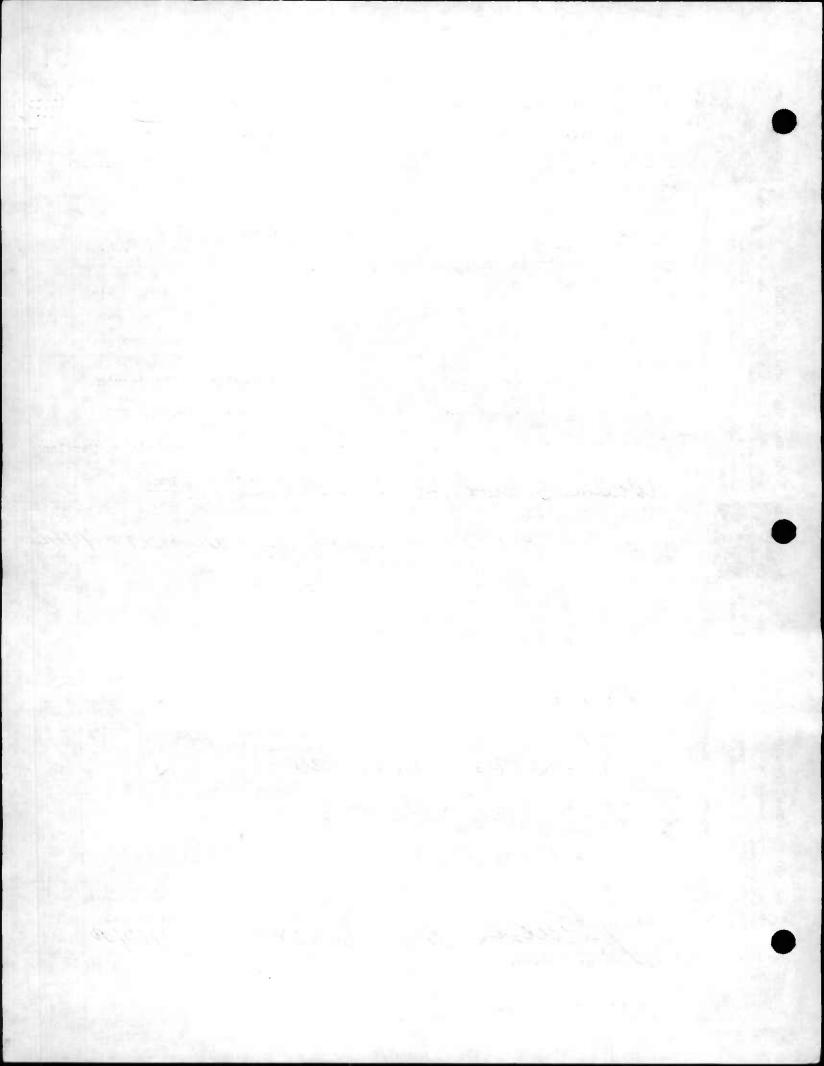
is a American mark

David	William	Geppi.	State of	Marylar		artmen			nd M	lental Hyg	giene () () 2	24	50
	Physician	Decedent's Name (First, Middle, La David Willie		ppi	-0.5					2. Date of Dea Month July		Yeer 2000	10.12	of Death
	/Medical Examiner	4e Facility Name (If not institution, gh Fallston Genera	re street and num	nber)			1	b. City, Tov		cation of Death		of Death	10.21	r el.1e
	irector	5. Sociel Security Number 6. S	-	7. Age (In yrs. 46	last birthdey) Yrs.	If Under Months	1 Yaar Deys		24 Hrs. Min.	8. Date of Birth (Month, De) Dec. 27	of Birth nth, Dey, Year) 9. Birthplece (State Country) MD			or Foreign
death with the Maryland		Usuel Residence of Decedent 10a. State 10b. County MD Baltimo	re		ty, Town or Lo				М		10d. Inside City 1 ☐ Yes 2			
2	or 2844 s be notified	10e. Street and Number				10f. Zip Code					10g. Citizen of What Country?			
	at, or items 23s Examiner must by Funeral	8610 Silver Knol 11. Merital Status 1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Dece Armed For 1 Yas If Yes, Giv Yeer or De	ces? 2 No e X		21128 13. Wes Decedent of Hispanic Origin? (Specify Yas or If Yas, specify Cuben, Mexican, Puarto Rican, etc.) 1 Yes 2 No Specify:					U.S.A. 14. Rai Bla	ce - Americ ck, White,	etc.	R. III
1215-0 within 72 ho	es 1 and 2 ahould be filed within of Health and 2 ahould be filed within of Health and Merical Hygiene. I fam 27 is marked other than other traumatic event, the Merical Popularian of the Merical American and the Merical American and the Merical American and the Merical American and the Merical American and the Merical American and the Merical American and the Merican 5. Decedent's E (Specify only highest gri Elementery/Secondary (0-12) 12 yrs.		-4or 5+)	16a. Deced (Give life.	dent's Usu- kind of wo DO NOT u		etion furing most)	of worki		16b. Kind of B				
riand 2		17. Fathar's Nema (First, Middla, Last Frank J. Geppi)		111	5 119	ircei			e (First, Middle, E. Zolt	Meiden Sumer		СУ	
Ore,		19e. tnforment's Neme/Reletionship (Gary Geppi – Brot 20e. Method of Disposition 1 ☑ Buriel 2 □ Cremetion 3 □	her	Stete	23 L.: Plece of Dispo cemetery, cree	incol	n Wo	ods W	ay,	Perry H	all, MD 20c. Location	211 - City or To	128 own, Stete	
Baltim permit. Pag December	Important any injury ance.	4 Donetion 5 Other (Specify) Dulaney Valley Mem'l Gard,7/19/00 Timonium, M 21. Signeture of Funeral Service Licensee William G. Dau William G. Dau 22. Nama and Address of Fecility Leonard J. Ruck Funeral Sand Address of Rd., Baltimore, MD 2121										al Ho	me,In	
/M Exa	sician edical iminer	23e. Pert1. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such as cerdiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximate Intervel Between Onset and Deeth Immediate Cause (Final disease or condition resulting in deeth) Due to (or es a consequence of):												setween
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The lew requires that the death certificate be executed within 24 hours after deeth.	attending physician and I for use as the bunal-transit clan/Medical Examine	Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest b. Due to (or es a consequence of): c. Due to (or es a consequence of): Due to (or es e consequence of):												
P.O. Box	d by the attending physicie etached for use as the but Physician/Medical	Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I.								23b. Did tobacco usa contributa to the cause of dea				
Division of Vital Records, or Attending Physician: The lew requires the star deeth.	ate hes been signed by the page 2 should be detached completed by Physic										b. Were autopsy findic available prior to complation of caus- of death?			
I Re	page 2									181	res 2□No		Yes 2	
Vita	irector.	25. Wes cese referred to medical axeminer? 1 ☼ Yes 2 ☐ No	Hospitel:	npatient 2X	ER/Outpetier	3 3 1 10	Oth	05:		h (Check only o		har /Snacii	6v)	
ion of	To the Funeral Director: After this cardificate he completally filled in by the funeral director, page Medical Certification: To Be Com	27. Menner of Deeth 1 Neturei 5 Pending 2 Accident investigation	28a. Dete d Fourit		28b. Time o Found 7:40		28c. Injur Wor	4 Nuising Fic		Home 5 Residence 6 Co 28d. Describe how injury occ Subject struc		rred	light	ning.
Divis	led in by the funer Certification:	3 Suicide 4 Homlcide 6 Could not be determined 28e. Plece of Injury - At home, frem, street, factory, office building, etc. (Specify) Sidewalk in front of a residence								28f. Location (8 City or Tow Joppa,	Street end Num vn, Stete) 5	ber or Rure 2 And	Route N	umber. Drive
Hosp 24 hou	Pletaly fill	29a. Certifier (Check only one) 1□ Certifying Pt 2□ Medical Example 100 Certifying Pt	nysician: To the miner: On the ba end menn	sis of examine	owledge, deetl etion end/or in	n occurred vestigetion	et the tin n, in my o	ne, dete and pinion, deel	d place, th occurr	end due to the red at the time,	ceusa(s) end m dete end piece	anner es s , end due t	tated. o the caus	e(s)
To the	To the										July 15, 2000			
	20	30. Nema end address of person who Dennis Chute M		e of death (Ite			n St	reet,	Bal	ltimore,	Maryla	and 2	1201	
	State Registrar	31. Dete filed (Month, Dey, Year)	32. Re	egistrer's Sign	eture	,								



State of Maryland / Department of Health and Mental Hygiene 00 2245

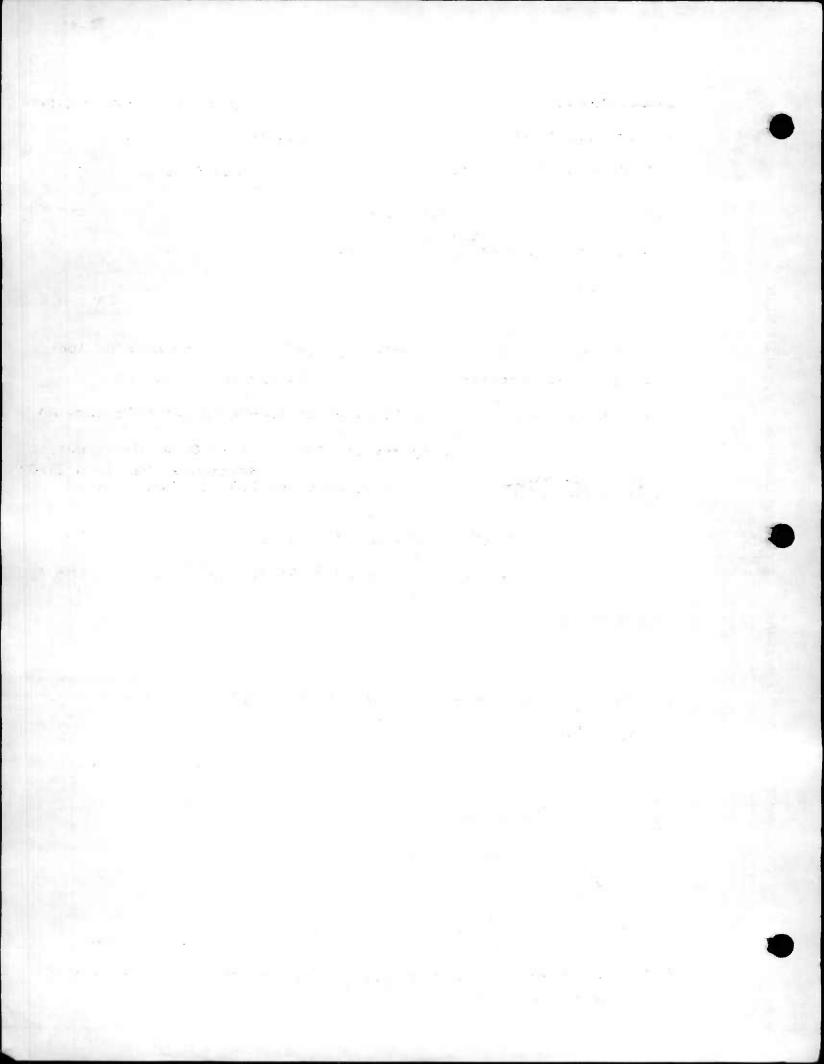
iysician		1. Decedent's Neme (First, Middle, Last)							Month Day Year			3. Time of Death		
/Medical		Katherine Gertrude Griefzu								July	11, 200			
kaminer	48	la Facility Name (If not Institution, give street end number)						4b. City, To	wn, or Loc	cation of Deeth	4c. County	of Death		
	В	Good Samaritian Hospital							Baltimore N/A					
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Yes 2 No If your Number, stated. to the cause(s)	



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Deeth 1. Decedent's Neme (First, Middle, Last) John H. Goodman Jr. Dey Month Yee Physician John J. Goodman 2000 July 11 01:22P.m. /Medical 4c. County of Deeth 4e Fecility Neme (If not Institution, give street end number) 4b. City, Town, or Localion of Deeth Examiner Good Samaritan Hospital Baltimore NA If Under 1 Year | If Under 24 Hrs. Birthplece (State or Foreign Country) 5. Sociel Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** 1 M 2□ F Months Vre Director 219-40-3604 53 09-10-46 MD Usuel Residence of Decedent with the Marylend permit. Pagas 1 and 2 should be filed within 72 hours after death with the Marylan Department of Haalth and Mental Hygiene.
Important: If item 27 is merked other than "natural", or items 23a or 28a-f show any injury or other treumatic event, the Maximal Examine ment by motified an page. 10a. Stele 10c. City, Town or Location 10b. County 10d. Inside City Limits XYes 2□No Director Baltimore MD NA 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? Apt. "A" IISA 21239 1200 Linworth Avenue Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Rece - American Indien. Bleck, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Detes: 1 ☐ Never Merried 2 ☐ Married 1 Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementery/Secondary (0-12) College (1-4or 5+) Self employed Goodman
18. Mother's Neme (First, Middle, Melden Surneme) 10th Grade 17. Father's Neme (First, Middle, Last) Goodman Bailbonds Be Josephine Durant John Η. Goodman P 19a. Informent's Neme/Relationship (Type, Print) 19b. Malling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 1200 Linworth Avenue Apt. 2A Baltimore, MD. Goodman Mildred 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, Stete Buriat 2 Cremetion 3 Removel from Stete King Mem.Pk. Cem. 07-17-2000 Randallstown, MD re of Funeral Service Lic 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Peril. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardlec or respiratory errest, shock, or heart failure. List only one cause on each line. Approximete Intervel Between Onset end Deeth **Physician** Hrs /Medical Immediate Ceuse (Finel My ocen diseese or condition resulting in deeth) Examiner Examiner Kers 4 physician and s the burial-trensit The law requires that the death certificate be executed Sequentially list conditions, if eny, teeding to immediate cause. Enter Underlying Ceuse (Diseese or injury that initiated events resulting in deeth) Lest Due to (or as a con Division of Vital Records, P.O. Box 68760, Physician/Medical Due to (or es e consequence of) attanding p Pert II. Other significent conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by tha should be datached left ventrialer well pretun 1 ☐ Yee 2 ☐ No 3 Probably 4 XUnknown è 24b. Were eutopsy findings evellable prior to completion of cause of death? 24e. Wes en eutopsy Completed Newhoroarters sileurs s cartificata has t director, paga 2 s 1 Yes 2 □ No 1 XYes 2 No or Attending Physicien: director, 25. Wes case referred to medical exeminer? Be 26. Plece of Deeth (Check only one) 1 AYes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Inpatient 2 KD ER/Outpetient 3 ☐ DOA this Aftar thi 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28c. Injury et Work? 28d. Describe how injury occurred 28b. Time of 1 Naturel 5 Pending death. 1 Yes 2 No investigation 2 Accident after death Director: / d in by the f 6 Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital or within 24 hours aft To the Funeral DI complately filled in 29a. Certifier (Check only one) 🗹 Certifying Physician: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted. Medical /2 Medical Examiner: On the pasts of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manufacture stated. 29b. Signature and title of certifier 29d. Date signed (Month, Dev. Year) 29c. License number July 12, 2000 30. Name and address of person who completed cause of deeth (Item 23e) (Type, Print) Sheldon M. Glusman M.D. Good Samaritan Hospital 5601 Loch Raven Blvd. 31. Dete filed (Month, Dey, Year) 32. Registrer's Signature onks JUL 15 2000

DHMH 16 Rev 6/95

Registrar



State of Maryland / Department of Health and Mental Hygiene [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Mary K Hickox July 10 2000 11:30PM /Medical 4a Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Severna Park Genesis Elder Hours Min. 8 Date of Birth (Month, Day, May 10 If Under 1 Year 9. Birthplace (State or Foreign Country) Pennsylvania 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1916 Days 1 M 2 KF Yrs. Director 210-09-7168 84 Usual Residence of Decedent 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Director Pasadena Maryland <u> Anne Arundel</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? iner mast be n 8012 Mansion House Crossing 21122 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Waa Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after begannent of Health and Mental Hygiene. If ferm 27 is marked other than "natural", or its any injury or other traumetic event, the Medical Examines 1 Yes 2 No If Yes, Give Yeer or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0020 1 Yes 2 XNo Specify: White Specify ğ 3√ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent'a Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondary (0-12) College (1-4or 5+) 12 Cafeteria Manager 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Meiden Sumeme) Be Ford Mary John Fetterman 19e. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) daughter 8012 Mansion House Crossing Pasadena, MD 21122 Beverly M. Utterback 20b. Place of Disposition (Name of cemetery, crematory or other place, 20e. Method of Disposition 20c. Location - City or Town, State ty☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) National Memorial Park 7/15/00 | Falls Church Virginia 22. Name and Address of Fecility 21. Signeture of Euneral Service Licensee Stallings Funeral Home P.A. 3111 Mountain Road Pasadena, MD 21122 23a. Pert I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart feilure. List only one cause on each line. Approximate Intervel Between Onset end Death **Physician** Immediate Cause (Final disease or condition resulting in deeth) /Medical Poxemia
Due to (or as a consequence of): Examiner Physician/Medical Examiner Stage Dementa sician and burial-transit The lew requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) physician s the buria P.O. Box 68760, Due to (or es a consequence of) been signed by the attending p should be detached for use as Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yee 2 No 300 Probably 4 Unknown Records. Completed by 24b. Were autopsy tindings evailable prior to 24a. Wes an autopsy parlormed? completion of cause of deeth? page 2 s 1 Yes 2 No 1 Yes 2 No certificate Division of Vital or Attending Physician: funeral director, 25. Was case referred to medical Be 26. Place of Deeth (Check only one) Other: 45 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2KINo Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Dete of Injury (Month, Day Year) 27. Menner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 SNaturel 5 Pending 1 Yes 2 No death. investigetion 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 28e. Place of Injury - At home, ferm, street, fectory, office building, etc. (Specify) filled in by 4 ☐ Homicide Hospital Medical 29a. Certifier 🔟 Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and menner as stated. To the Hosp within 24 hor To the Fune completely fi (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signatur and fittle of certifier 29c. License number 29d. Dete signed (Month, Dey, Year) 053462 ddress of person who completed cause of death (Item 23a) (Type, Print) ELDER CARE MUNESES/GENESIS D 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22454 amended item# 20a per fd g785 7-26-00wj Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year **Physician** July John Hilker 12, 2000 8:17 PM /Medical JONN F.

4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3747 Hickory Avenue Baltimore N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day Year) 908 7. Age (In yrs. last birthday) 5. Social Security Number 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2□ F 92 Maryland 215-03-9943 Yrs. Director Usual Residence of Decedent with the Maryland 10a. Stete 10b. County 10c. City, Town or Location 10d. fnside City Limits pemit. Peges 1 and 2 should be filed within 72 hours efter death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or frams 23a or 28a-f ahow any injury or other treumatic event, the Medical Examinat must be notified at Maryland N/A Baltimore XXYes 2 No Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3747 Hickory Avenue 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-ff Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? YYes 2 No Tryes, Give Year or Dates: WWII Never Married 2 Married altimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Interior Finishing Unknown Painter 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rachael A. Gosnell John Spencer Hilker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Reletionship (Type, Print) 409 Washington Ave. Ste 900 Towson, MD21204 Louis Friedman (Attorney) 20a. Mettlor of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Mt. Pleasant Cemetery 7/17 Gamber, Maryland urial 2 Gremation 3 CRi onation 5 Comer (Specify) State 101 4 DD 22. Name and Address of Facility 21. Sign Burgee-Henss-Seitz Funeral Home, Inc 3631 Falls Road, Baltimore, MD ter the mode of dying, such as cardiac of respiratory arrest, 21211 Approximate Interval Between Onset and Death ations that caused the death. Do not ent 23a. Part1. Enter the disease, or complete shock, or heart feilure. List only on **Physician** /Medical Immediate Ceuse (Final disease or condition resulting in death) **Examiner** Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leeding to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and physician s the burial Division of Vital Records, P.O. Box 68760 Physician/Medical Due to (or as a consequence of): signed by the a 23b. Did tobacco use contribute to the cause of death? Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? Completed completion of ceuse of death? 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physicien: Be 25. Was case referred to medical 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home Sesidence 6 Other (Specify) 1D Yes 2 No Certification: To After this funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Atatural 5 Pending investigation 1 ☐ Yes 2 ☐ No death. ours after death. nerei Director: A filled in by the fu 2 Accident 6 Could not be determined 3 Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide To the Hospital within 24 hours a To the Funerel C Hospital Certifying Physician: To the best of my knowledge, deeth occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the best of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier edical completely (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Meli 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1CH ARD DIAMIND

DHMH 16 Rev 6/95

State

Registrar

31. Date filed (Month, Day, Year)

JUL 1

7 2000

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene 00 22455

			00	runoato	of Death		Reg. No.				
- · · ·	1. Decedent's Neme (First, Middle,					2. Date of Month	Death Day	Year	3. Time of Death		
Physician /Medical	Joseph Hube	ert Hall,	Sr.			July		real	1545 p		
Examiner	4a Facility Name (If not institution, g	give street and number)			4b. City, Town	, or Location of De	eath 4c. County	of Death			
	2828 Miles Avenu	ie			Balt	imore	N/A				
Funeral			(In yrs. last birthde)	Months D		Hrs. 8. Date of (Month,	Birth Day, Year) 9,1943	9. Birthpia	ca (Stata or Foreign)		
Director	220-38-5967	X-XM 2□ F 5	6 Yrs.			Sept	9,1943		yland		
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da f	10a. State 10b. County Maryland N/A		10c. City, Town or L Baltimo					10	d. Inside City Limit XXYes 2□N		
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be notified Director	10e. Street and Number			10f. Zip Co	21211		10g. Citizen of V		ry?		
	2828 Miles Av	venue									
r tems 23 doer must Funeral	11. Maritef Stetus	Armed Forces?	Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yas, specify Cuban, Mexican, Puerto Rican, atc.) 14. Race - American Black, White, et								
Y F	1 □ Never Married 3 Married	If Yes, Give **					Specify	· Wh	nite		
LEAN d by	3 Widowed 4 Divorced	Year or Dates:									
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2 E	Elementary/Secondary (0-12)	College (1-4or 5+	.)				Dolo				
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B sell	17. Father's Name (First, Middle, La				THE OLD	Transfer of the same	dle, Maiden Sumam	10/			
To Men	John Heni						olf	2022			
is m	19a. tnformant's Name/Ratationship	(Type, Print) (Wife)	19b. Mai	ling Address (S	treet and Number	or Rural Route Nu	mber, City or Town, timore,	Stata, Zip (71 a 2121		
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or of	20a. Mathod of Disposition 1 ☐ Burial 2 TyCremation 3	☐Removal from State	cemetery, cri	emetory or othe	remator	У	20c. Location -	City or Tov	vn, State		
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mport mport any inj	21. Signature & Floerful Service Licensee 22. Name and Address of Fecility										
8822	Burgee-Henss-Seitz Funeral Home, Inc. 3631 Falls Road, Baltimore, Maryland										
	23a. Part1. Entar the disease, or co shock, or haart failure. List or	omplications that caused t	the death. Do not e	nter the mode o	f dying, such as ca	ardiac or respireto	y errest,		Approximate		
ysician	Snock, or haart failure. List or	ny ona causa on each tine							Interval Batween Onset and Death		
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician 240 1, 2000 4c. County of Death on Johnson Mary Lou /Medical 4a Facility Name (If not institution, give street and number b, City, Town, or Location of Death Examiner Crfy altimore Hours Min. 8. Date of Birth (Month, Day, Year) 0-7-1923 If Under 1 Yeer 9. Birthplece (Stete or Foreign Country) Va 7. Age (fn yrs. last birthday) **Funeral** Months Days 1 M 2 F 226-30-5570 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits NOYes 2□No Director Baltimore Md N/A 23s or 28s-1 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 21215 USA 3807 Glengyle Avenue Funeral 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 11. Merital Status 1 Yes 2 No 1 Never Merried 2 Married Specify: Black b 1 Yes 2 No Specify: 3\XWidowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry filed within Elementary/Secondary (0-12) 12th grade Church Home Hospital College (1-4or 5+) Cook 17. Fether's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be Mental Mary Matthews Barnett Saunders Department of Health and Mi Important: if Item 27 is mark any injury or other traumatik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3807 Glengyle Avenue **Erances** Edwards- Daughter Baltimore, Md 21215 altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Garrison Forest Vet 7-17-00 Owings Mills, Md 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility March F/H West 21. Signature of Funeral Service Licenses 4300 Wabash Avenue Baltimore, Md21215 23a. Pert1. Enter the disease, or complications that coulon, the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart/fellude. List only one cause on one line. Approximate Interval Between Onset and Death **Physician** . Diabetes Mellitus Immediate Cause (Finel disease or condition resulting in death) /Medical Examiner brovascular Examiner The law requires that the death certificate be executed burial-transit Sequentielly list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or Injury that initiated events resulting In death) Last Due to (or as a consequence of): Box 68760 Physician/Medical the Due to (or as a consequence of) ertension 98 USB Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part I. 23b. Did tobacco use contributa to the causa of death? P.0. 1 Yes 2 No 3 Probably 4 Unknown by Records, 24b. Were autopsy findings available prior to completion of ceuse of death? 24e. Wes an autopsy performed? Medical Certification: To Be Completed page 2 certificate has 1 Yes 2 No 1 ☐ Yas 2 ☐ No of Vital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funerai 27. Manner of Death 28a. Dete of Injury (Month, Dey Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural Division 5 Pending investigation after death.

Director: Aft
d in by the fur 1 Yes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 3 ☐ Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours af To the Funeral Di completely filled in 10 Certifying Physician: To the best of my knowledge, deeth occurred at the time, dete and plece, and due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examination and/or Investigation, in my opinion, deeth occurred at the time, dete and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Joth 11/00 30, Name and address of person who completed cause of deeth (Item 23a) (Type, Print) CV aryland Greneral

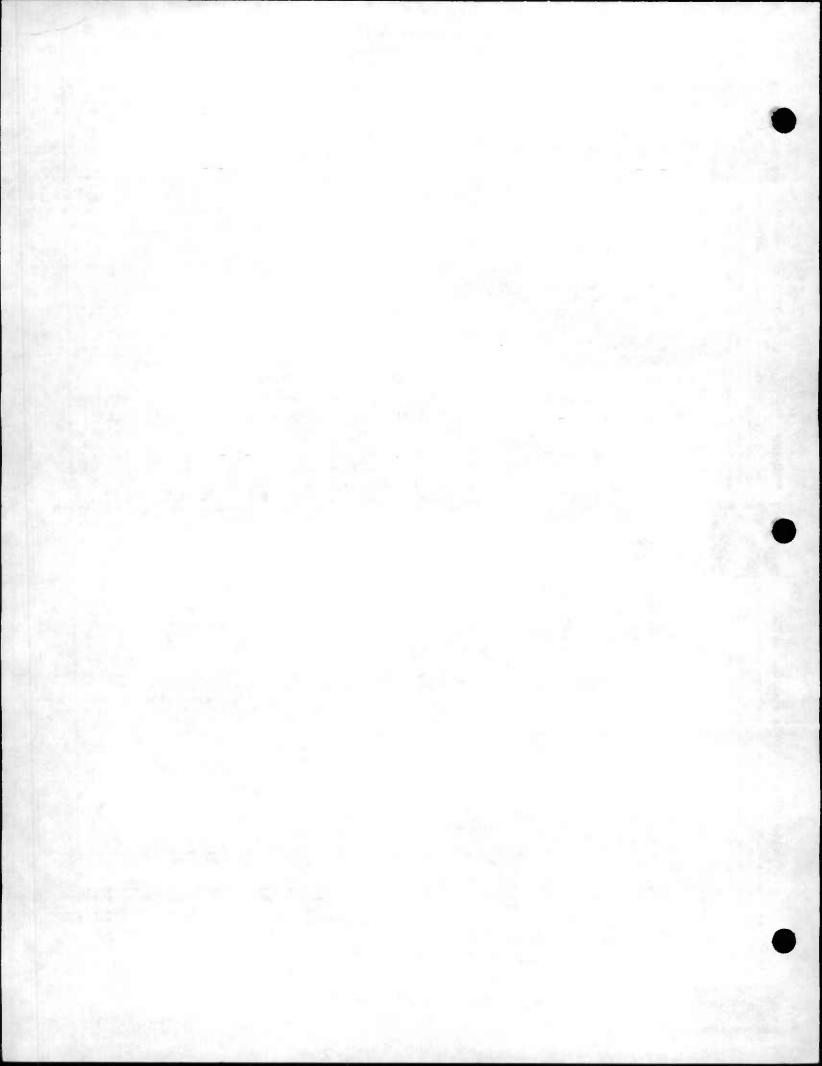
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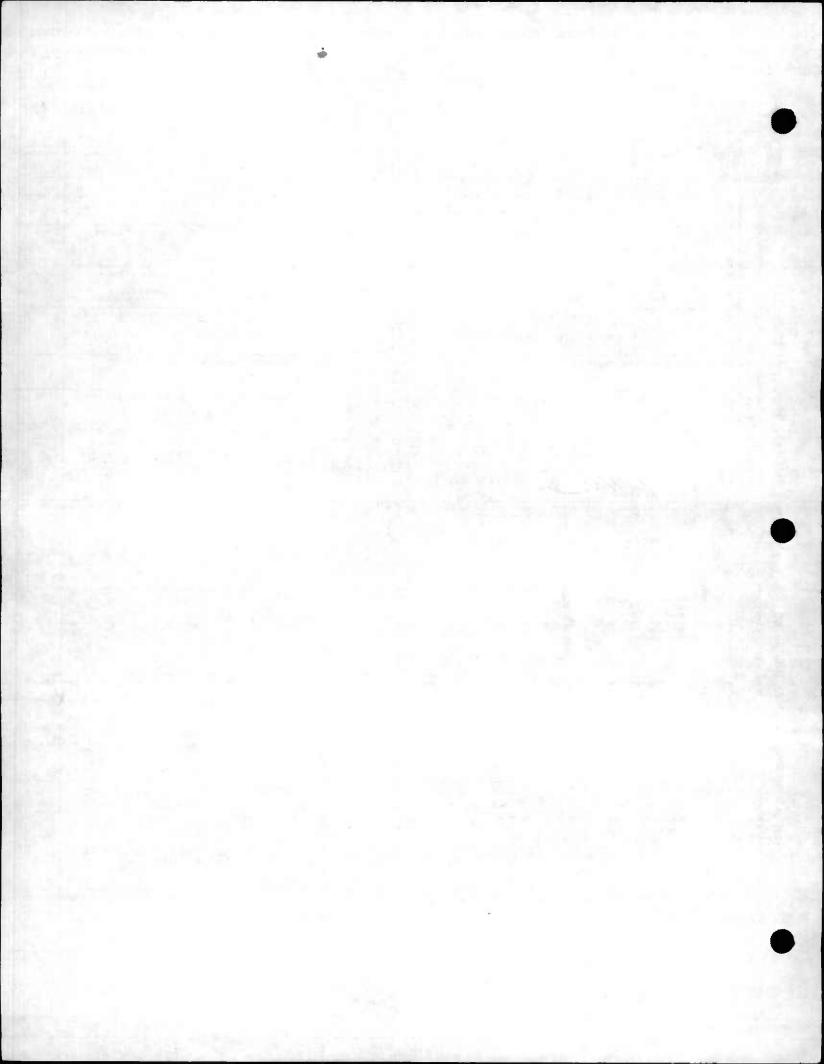
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32 Registrar's Signature



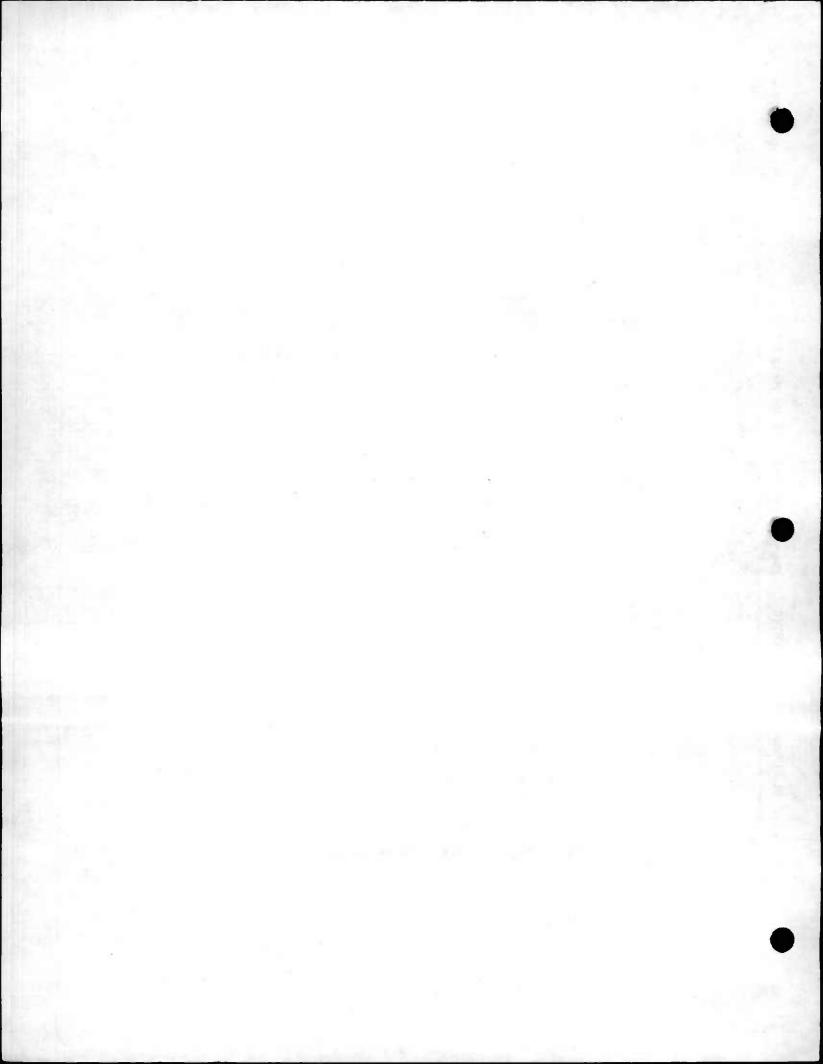
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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	3 30	Name and address of names who						1						



State of Maryland / Department of Health and Mental Hygiene 22458 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician Treva 13, Kienle 2000 2:30am July /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ll G Wind Mill Chase Sparks Baltimore If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Funeral 1□M 200 F Yes 72 Director 214-22-3722 Oct 21, 1927 Maryland Usual Residence of Decedent the Meryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** "natural", or items 23s or 28s-f show address Examiner must be notified at 1 Yes 2X No Director Maryland Baltimore Sparks 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? filed within 72 hours after death with the Hyglene.
Sther than "natural", or frama 23a or 2 ent, the Medical Examination at the Medical Examination at the Medical Examination and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard and the standard a USA ll G Wind Mill Chase 21152 Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w. Department of Health and Mental Hyglen important: If them 27 ie marked other thy any injury or other traumatic event, the page. 10 n/a Assistant Bank Manager Banking Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Marguerite Maynard Charles Luther Allison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eugene C. Kienle/Husband 11 G Wind Mill Chase, Sparks, MD 21152 20a. Method of Disposition Date 20c. Location - City or Town, State 1 N Burial 2 ☐ Cremation 3 ☐ Removal from State 7/17/00 Druid Ridge Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Pikesville, Maryland 22. Name and Address of Facility Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Enter the dis ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death Physician Immediate Cause disease or condition resulting in death) Medical Examiner Due to (or as a consequence of) The law requires that the death certificate be executed Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Box 68760, Physician/Medical å Due to (or as a consequence of): 23b. Did tobacco use contribute to the cause of death? P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown à aigned t Records, à 24b. Were autopsy findings available prior to Completed 24a. Was an autopsy completion of cause of death? ž 1 Yes 2X No 1 ☐ Yes 2 No certificate of Vital 25. Was case referred to medical å 26. Place of Death (Check only one) Other: 4 Nursing Home 5 N Residence 6 Other (Specify) 1 Yes 2N No Certification: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 音 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affar Division Attending 1 (XNatural 5 Pending investigation 1 Yes 2 No 2 Accident after death 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 8 filled in 24 hours a e Funeral C 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the 29a, Certifier Medical (Check only one) er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I å 29b. Signature and alth of corp 29c. License number 29d. Date signed (Month, Day, Year) July 13, 2000 s of person who completed cause of death (Item 23a) (Type, Print) John C. Downs, MD 7505 Osler Dr., suite 302, Towson, MD 21204 31. Date filed (Month, Day, Year) 2000 Registrar Signature State Registrar



Please Type or Print in Black Indelible ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Data of Death 1. Decedent's Nama (First, Middle, Last) 3. Tima of Deeth Day Month or Year **Physician** atherine -15 E. 20 2000 /Medical PIM 4a Facility Nama (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimore Center Randall-stown
If Undar 24 Hrs. 8. Data of Birth
Month, Day, Y Hill Nursing 5. Social Security Number If Under 1 Year Months Days 6. Sex Birthplace (State or Foreign Country) 8. Data of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) **Funeral** 1□M 20F Yrs 218-03-4509 Usual Residence of Decedent Director 03-08-1920 permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Heelth and Mental Hygiene. Importants if Item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examiner must be notified at 2008. 10a. State 10b. County 10c. City, Town or Location 10d. Insida City Limits Director 1 Yes 2 No MD Baltimore Randallstwon 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4511 Robosson Road 21133 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yas, specify Cuban, Maxican, Puerto Rican, etc.) 14. Race - Amarican Indian, Black, Whita, etc. 11 Marital Status 1 Never Married 2 Married 1 Yes 2 No Specify: 21215-0020 white Specify P 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) housewife none Baitimore, Maryland 17. Father's Nama (First, Middle, Last) 18. Mothar's Nama (First, Middle, Maiden Sumame) 8 Benjamin P. Tomlinson Bertha E. Zink 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Chapel Hill Nursing Center 4511 Robosson Road Randallstown, MD 21133 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stete Data 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☑ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens Ronald S. Wa 22. Name and Address of Facility
State Anatomy Board Director Wade. 655 W. Baltimore Street anun Mill Baltimore, MD 21201 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, and or heart tailure. List only one cause on each line. Approximata Interval Between Onset and Death **Physician** Immediate Cause (Finel diseasa or condition resulting in death) /Medical · Chronic Luns restrictive Examiner 1.54456 Due to (or as a consequence of): Physician/Medical Examiner buriel-transit or Attending Physician: The law requires that the death certificate be executed Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): physicien s the burie Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Pert I. 23b. Did tobacco use contribute to the cause of death? been signed by should be detac 1 Yes 2 No 3 Probably 4 Unknown Hyperlunsing 2 24b. Were eutopsy findings availebla prior to complation of causa of death? Be Completed 24e. Was an autopsy performed? Seizure 1 Yas 2 No 1 Yes 2 No certificate 25. Was case refarred to medical axaminer? director, 26. Place of Death (Check only one) Hospitat: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Homa 5 Rasidence 8 Othar (Specify) Certification: To Hospital or Attending Physical Section 24 hours after death.
 Funeral Director: After this the funeral 28a. Data of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation 281. Location (Street and Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 ☐ Suicide 28e. Placa of Injury - At homa, farm, street, factory, office building, etc. (Specify) filled in by 4 ☐ Homicide

P.O. Box 68760, Records, Division of Vital

1 Certifying Physician: To the best of my knowledge, death occurred at tha tima, date and place, and dua to tha causa(s) and menner as stated.

2 Medical Examiner: On the basis of axamination and/or investigation, in my opinion, daath occurred at tha time, data and place, and due to tha ceuse(s) and manner stated. 29a. Certifier (Check only one)

30. Nema and address of person who completed cause of death (ttern 23a) (Type, Print)

029085 2000

29d. Data signad (Month, Day, Year)

J -Allen Chincus 5310 010 Court 31. Data filed (Month, Day, Year) 32. Registrar's Signatura

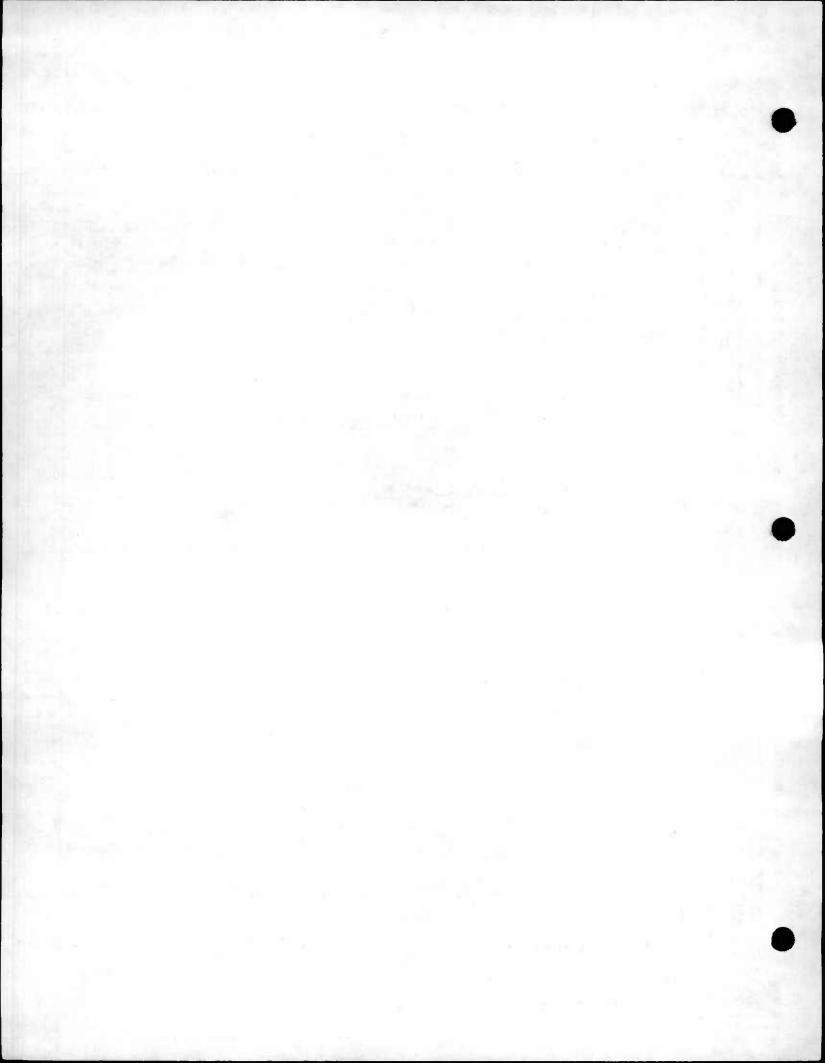
State Registrar

Medical

29b. Signature and titla of certified

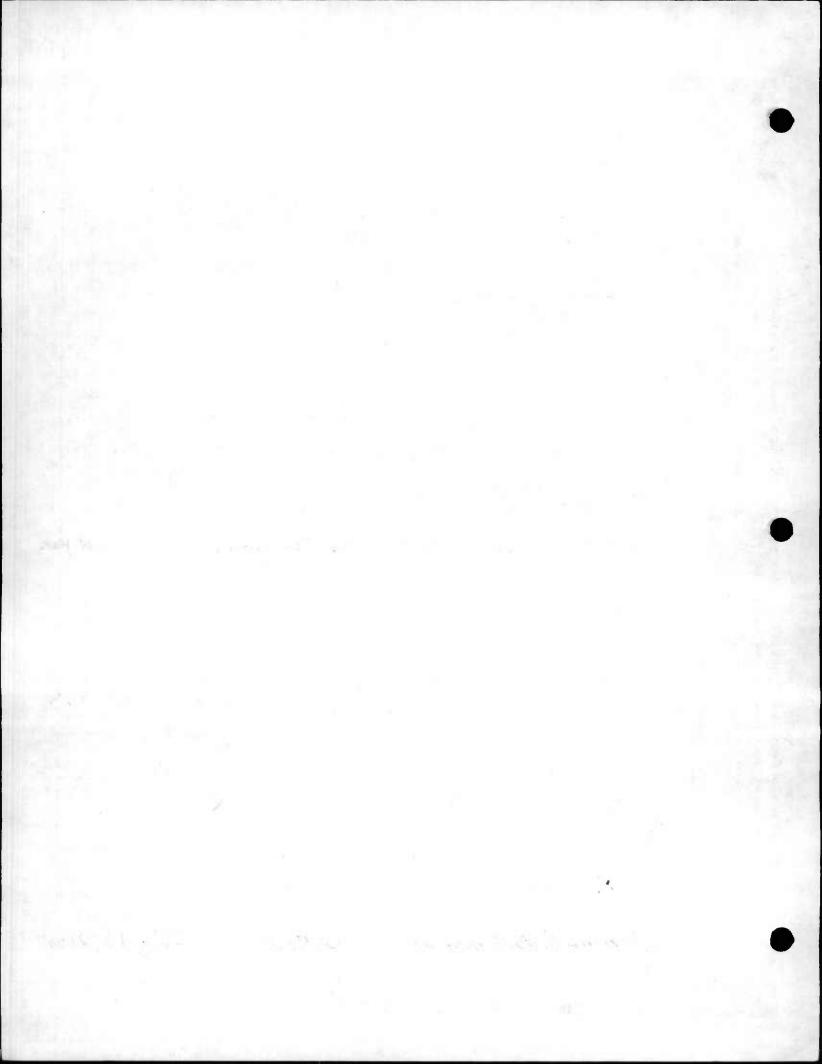
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To the Hosp within 24 hou To the Fune completely fi



State of Maryland / Department of Health and Mental Hygiene 00 22460.

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Examiner		(If not institution, gi						wn, or Location of D		y of Death		
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Piease Type or Print in Black Indeible Ink. Assure Ail Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Year 5:00 e phanie 2000 une 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Loc 4c. County of Death ion of Death Itimore City 5. Social Security Number Birthplace (State or Foreign Country) MARYLAND 8. Date of Birth 1 M 2 1 F 0 MARCH 216-57-4894 23,00 Usual Residence of Decedant 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. PITTSVILLE PITTSVILLE 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3445 TINGLE ROAD 21850 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Was Decedent Ever in U,S. Armed Forcas? Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Specify: KOREAN 1 Yes 2 No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) MAN KIM SON SONG 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Code) 3445 TINGLE ROAD PITTSVILLE, MARYLAND 20850 MR. MAN KIM- FATHER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) TOWNSON, HOLLTOP SERVICE CORP16/16/00 MARYLAND 21. Signature of Funeral Service Licensee CAIN 22. Name and Address of Facility LEONARD J. RUCK, INC. PER. DVR. 5305 HARFORD ROAD BALTIMORE MARYLAND212 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory strest, shock, or heart teilura. List only one cause on each line. Approximata Interval Between Onset end Death Immediate Causa (Final disease or condition rasulting In death) SEPSIS Dua to (or as a consequence of): LTYPOPLASIA days ONGENITAL ADRENAL Due to (or as a consequence of) UNG Dua to (or es e consequence of): 18 day EMATURI Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 XNo 3 Probably 4 Unknown MB1640US GENITALIA 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an sutopsy performed? ROMBOCYTOPENIA

Physician /Medical Examiner

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After death.

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To the Hospital or Attand within 24 hours after deat To the Funeral Director:

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Certification: To

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The law requires that the death certificate be axecuted

P.O. Box 68760,

Records,

Division of Vital or Attanding Physician: **Physician**

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Examiner

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permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: If flem 27 is marked other any injury or other traumatic avent ance.

filed within 72 hours after

21215-0020

Baltimore, Maryland

Director

Funerai

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Be

Physician/Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that included a senter. that initiated evants resulting in death) Last

1 Yes 2 No 1 ☐ Yes 2 No

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	examiner?	0	Hospital: 1 Inpatient	2 ER/Outpatient	3□	DOA Other:	4 Nursing I	Home 5 ☐ Residence 6 ☐ Other (Specify)
27.	Mennar of Death Netural Accident	5 Pending investigation		ar) 28b. Tima of Injury	М	28c. Injury at Work?		28d. Describe how injury occurred
	3 ☐ Suicide 4 ☐ Homicide	6 Could not be determined	28a. Place of Injury - building, etc. (S	At home, farm, stree	t, fact	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, Stata)

29a. Certifier

1 Certifying Physician: To the best of my knowledge, death occurred at the time, data and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29b. Signature Trys 110g of official

EDWAR? LAWSON

31. Data filed (Month, Day, Year)

29c. License number

29d. Dete signed (Month, Day, Year) JUNE 10, 2000

State Registrar rerson who completed cause of death (Item 23a) (Type, Pont) Baltimore mi) 21287 600 N. 32. Registrar's Signature

Sieven and American Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence Commence C Bability and service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service of the service A.

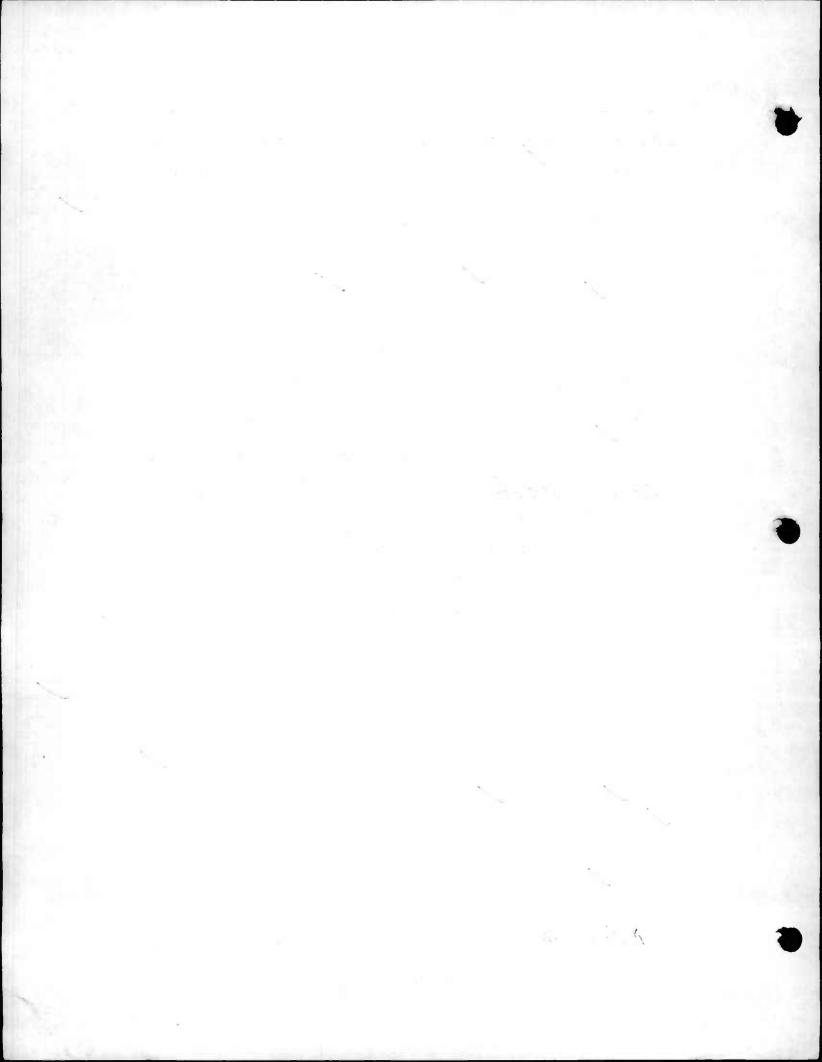
Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** William Liller 06 03 2000 0334 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner University of Maryland Medical System Baltimore If Under 24 Hrs. 8. Date of Birth
Hours Min. (Month, Day, Year) 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) Birthpiace (State or Foreign Country) **Funeral** 15 M 2 F Months Days Yrs. Director 184-30-5526 63 Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. Cltv. Town or Location 10d. inside Çity Limits Peges 1 and 2 should be filed within 72 hours efter death with the Marylar neat of Heath and Mental Hygiene.
If I flem 27 is marked other than "natural", or items 23a or 28a-f shown it I flem 27 is marked other than "natural", or items 20 or 28a-f shown into other traumatic event, as begins Exprise must be natified. 1 Yes 2 No Director N/AVA Alexandria 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Radcliffe Dr. USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cubas Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 14. Race - American Indian. 11. Marital Status Biack, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No 21215-0020 Specify: White Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Eiementary/Secondary (0-12) College (1-4or 5+) Painter Contractor Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Ellsworth Liller Virginia Shillinburgh 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 306 13th St., Monaça, PA Virginia Bogaert 20b. Piace of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Peges
Department of I
Important: If Ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 06/05/00 Catonsville, MD Metro Crematory 21. Signature of Funeral Service License 22. Name and Address of Facility Chavis Funeral Home, P.A., 2007-09 Eastern Av. Baltimore, MD 21231 - (41 c) or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, List only one cay in on each line. 21231 - (410) 342-7400 23a. Part 1. Enter the disease shock, or heart failurg. Approximate tnterval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical a Congestive Heart Failure Examiner Due to (or as a consequence of): b. Myocardiel Infarction The lew requires that the death certificate be executed buriel-transit Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Box 68760. c. Coronary Artery Disease Physician/Medical Due to (or as a consequence of): for use as the d Anoxic Brain Injury ate hes been signed by the c page 2 should be deteched P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown Division of Vital Records. þ 24b. Were autopsy findings available prior to completion of cause of death? Be Completed 24a. Was an autopsy performed? 1 ☐ Yes 1 ☐ Yes 2 ☐ No certificate Hospital or Attending Physician: director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 1 Yes 2 No 2 ER/Outpatient 3 DOA this the funeral 27. Mann of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. injury at Work? 28d. Describe how Injury occurred After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours efter death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Piace of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and piace, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. 29a. Certifier Medical To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number Au4176435H10011 06/03/00 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Brian Hill, M.I 31. Date filed (Month, Day, Year) JUL 17 2000 21 S. Greene St., Baltimore, MD M.D.

37. Registrar's Signature

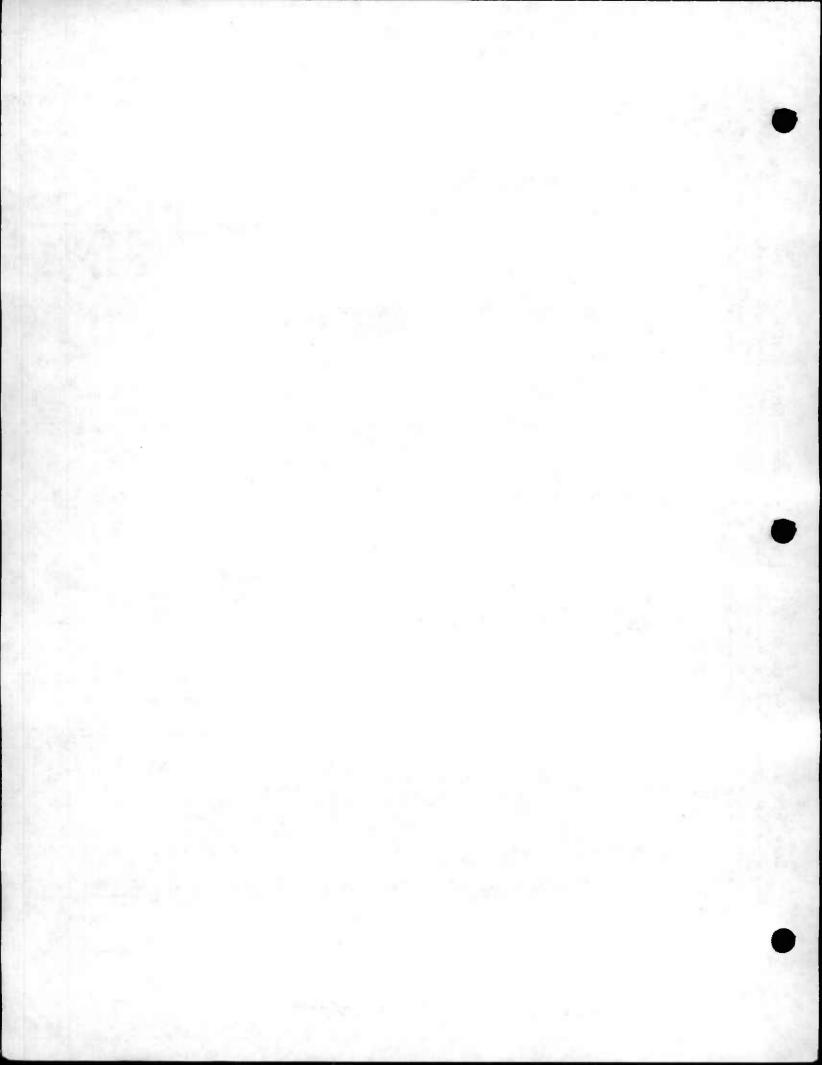
DHMH 16 Rev 6/95

State Registrar



State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Data of Death 3. Time of Death Dey Month 7 **Physician** 12:45 PM LITSINGER _ MABEL 10 00 /Medical 4c. County of Death 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore Baltimore ALICE Nursing HOME MANOR If Under 1 Year If Under 24 Hrs. 6. Date of Birth Months Days Hours Min. Marth Day, 1910 9. Birthplaca (State or Foreign 5. Social Sacurity Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1□ M 25 F 214-22-8493 90 Director Kentucky Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits N/A Maryland Baltimore XX Yes 2 No Director terns 23s or 25s-f 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 2065 Druid Park Drive 21211 USA Funeral 12. Was Decedant Evar in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yas or No-if Yes, specify Cuben, Mexicen, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int. If Item 27 is marked other than "natural", or ite 1 ☐ Yes 2 No If Yes, Give 1 ☐ Never Married 2 ☐ Married Maryland 21215-0020 1 ☐ Yes 2 ☑ No Specify: Specify White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Collega (1-4or 5+) Seamstress Clothing Industry Unknown 17. Father's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) William Nicholas Felty Myrtie Lou Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Brenda Mumau (Granddaughter) 2174 Druid Park Drive, Baltimore, Maryland 21211 altimore, 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of the Important: If its any injury or of Cremetion 3 Removal from State Glen Haven Memorial 7/14/00 Glen Burnie, Maryland 5 Other (Specify) Funeral Service License 21. Signatur 22. Name and Address of Facility Burgee-Henss-Seitz Funeral Home, Inc. 21211 23a. Part 1. Errer the disease, or complications that ceused the death. Do not enter the mode of dying, such as cerdiac or respiratory arrest, shock, or heer failure. List only one ceuse on each line. Approximate Interval Between Onset and Death **Physician** /Medical Immediate Cause (Final andio Pulmonary disease or condition resulting in death) Examiner Examiner The law requires that the deeth certificate be executed Sequentially list conditions, if any, leading to immadiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Box 68760. physician Diabeles Physician/Medical the Due to (or as a consequence of): P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown þ of Vital Records, 24b. Were autopsy findings available prior to completion of ceusa of deeth? Completed 24a. Wes an autopsy After this certificate hes 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical Medical Certification: To Be 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 2 Accident funerel 28a. Dete of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred i or Attending P Division 5 Pending investigation 1 Yes 2 No I Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital of within 24 hours af To the Funeral Di completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at tha time, date and place, and due to the ceuse(s) and manner as stated.
2 Medical Examiner: On the bests of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29b. Signature and title of certifier 29c. Licansa number 29d. Date signad (Month, Day, Year) 07/10/00 D 20146 evadoss Q. M 101 30. Nama and address of person who completed cause of death (Item 23a) (Type, Print) 9055 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2000 Registrar



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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 55: 212-32-0481 Certificate of Death 1. Decedent's Nema (First, Middle, Last) 2. Dete of Deeth 3. Time of Death Month Yeer GERTRUDE LEONARD JULY 8:50 AM 15 2000 4e Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth HOSPITAL SAMBRITAN RACTIMORE KALTI MORE MO If Under 1 Yaar | If Under 24 Hrs. 8. Dete of Birth (Month, Dey, Year) August 21, 9. Birthplece (State or Foreign 1932 Maryland 5. Sociel Security Number 7. Age (In yrs. lest birthdey) 1□M 21 F Months Days Hours 212-32-0481 Usual Residence of Decedent 10a. Stete 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 Yes 2 No N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 6013 Old Harford Road 21214 U.S.A. 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Yeer or Detes: Wes Decedent of Hispenic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rece - American Indian, Black, White, etc. 1 Never Merried 2 Married 1 Yes 2 No Specify Specify: White 3 ☐ Widowed 4 ☐ Divorced Decedent's Usual Occupetion
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Store Clerk Retail 12 17. Fethar's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumeme) Frank X. Leonard Gertrude M. Nies 19a. Informent's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Bernadette Brooks- Sister 2908 Putty Hill Ave. Baltimore, Maryland 21234 20e. Method of Disposition 20b. Plece of Disposition (Name of cemelery, cremetory or other place) 20c. Location - City or Town, Stete 1 ☐ Burlel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corpl 7/18/00 Towson, Maryland 21. Signature of Funeral Service Licensee Heather Cain 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214 leather aun Approximete Interval Between Onset end Deeth 23a. Pert1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, shock, or heart tailure. List only one cause on each line. immediata Ceuse (Finel disease or condition resulting in death) Sequentielly list conditions, if any, leeding to immediate causa. Enter Underlying Cause (Diseese or injury that initieted events resulting in deeth) Lest Due to (or es e consaquence of): Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? Advenal insufficiency 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings availabla prior to completion of cause of death? 24e. Was an autopsy performed? 1 Tes 1 Yes 2 No 26. Place of Deeth (Check only one) Hospitel: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpetient 3 DOA 28e. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury et Work? 5 Pending Invastigation 1 Yes 2 No

Examiner 10 The lew requires that the death certificate be executed Box 68760 physician Division of Vital Records, P.O. To the Hoaptal or Attanding Physician: The lew require within 24 hours statedeath.

To the Funeral Director: After this certificate has been signified in by the funeral director, page 2 should

/Medicat

Physician

/Medical

Examiner

Funeral

Director

items 23s or 28s-f show

Funeral Director

à

Be Completed

with the Maryland

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Haalth and Meniel Hygiene. Important: If Item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.

Physician

Maryland 21215-0020

Baltimore,

Examiner Physiclan/Medical þ Completed Certification: To Be Medical

25. Wes case referred to medical exeminer? 1 ☐ Yes 2☐ No 27. Manner of Death Neturel 2 Accident 28f. Location (Street end Number or Rural Route Number, City or Town, Stete) 6 Could not be 3 Suicide 28e. Plece of Injury - At home, ferm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner es stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date end place, and due to the cause(s) and manner estated. 29a. Certifier (Check only one)

State

Registrar

29b. Signeture end title of certifier

29c. License number P12556 29d. Date signed (Month, Day, Year) JULY 15, 2000

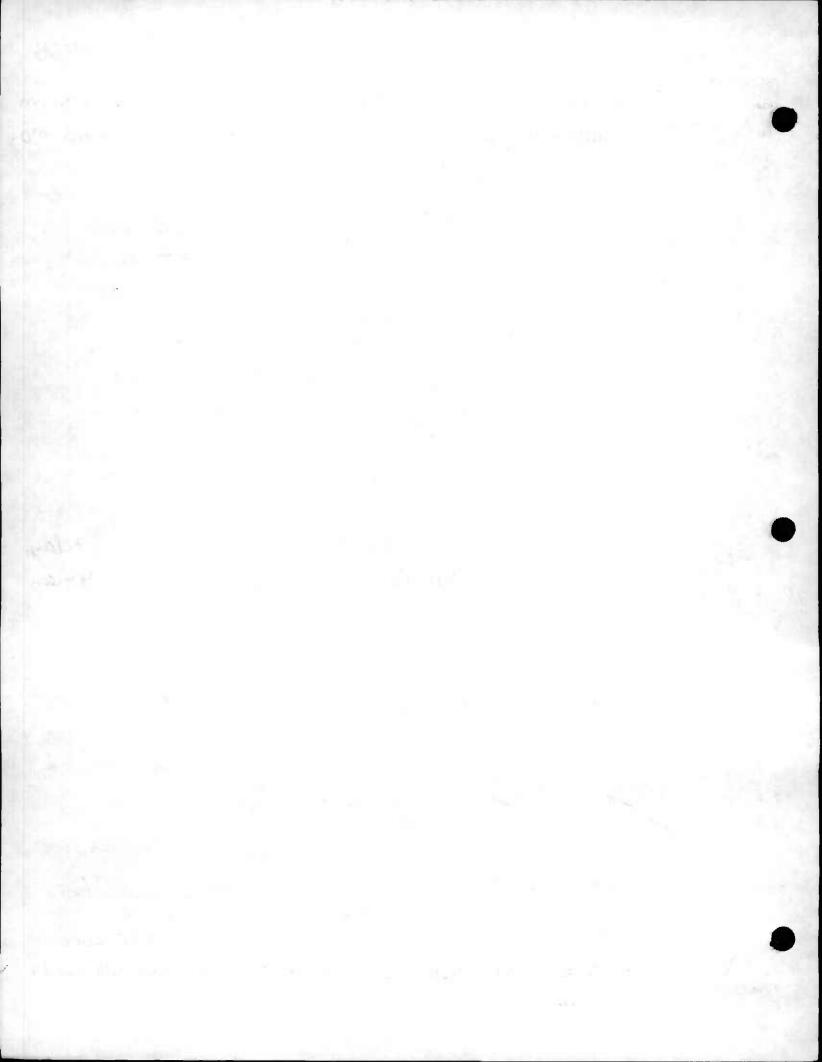
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30. Name and eddress of person who completed cause of deeth (Item 23a) (Type, Print)
A JAY CHAWUI MD CODD (MM) CHAWLA, MD, 31. Data filed (Month, Dey, Year)

JUL 17 2000

32. Registrer's Signeture

GOOD SMAIMITAN HOPITM, BATIMOKE MD 21239



State of Maryland / Department of Health and Mental Hygiene 22466 Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Date of Death 3. Time of Death Month 9,2000 **Physician** 1:26 P.M. Mildred Louvenia Lennon /Medical 4e Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. 5. Sociel Security Number 8. Date of Birth (Month, Day, Year) OCt. 10, 1925 9. Birthplace (Stete or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 1□M 2QF Trenton, NJ 172-22-8084 74 Yrs. **Director** Usuel Residence of Decedent death with the Maryland 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits rai', or items 23a or 28a-f aho Examiner must be notified at 1 Yes 2 □ No Director D.C. Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3985 1ST Street, S.W. 20032 U.S.A. by Funeral 12. Wes Decedent Ever in U,S. Armed Forces? Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indien, Bleck, White, etc. 11. Marital Stetus permit. Peges 1 and 2 should be filed within 72 hours after c Department of Health and Mentel Hyglene. Important: If Item 27 la marked other than "natural", or han any injury or other traumatic event, the Medical Examiner page. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Navar Married 2 ☐ Married Baitimore, Maryland 21215-0020 1 Yes 2K No Specify: Specify: Black 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grede completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) Homemaker Private 17. Fether's Neme (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Colonel Lennon Letha Davis Cromartie 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Caroline Kellem Daughter 1401 Hopeland Road, Wyncote, PA 19095 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State p☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) 7/15/00 Columbus, NC Lennon Cemetery 22. Name and Address of Fecility 21. Signetura of Funerel Service Licenses Latney's Funeral Home. CC0348 3831 Georgia Aye, NW, Wash, DC nu Approximate Intervel Between Onset end Death 23a Part 1. Enter the diseasa, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart tellure. List only one cause on each line. **Physician** Immediate Ceuse (Final disease or condition resulting in deeth) /Medical enemua Examiner Due to (or es a consequence of): Physician/Medical Examiner State or Attending Physician: The law requires that the death certificate be executed for use es the burial-transit Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initieted events resulting in death) Last Due to (or as a consequence of) Sept, Lemia

Due to (or as a consequence of): P.O. Box 68760, Salvas decul Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, Be Completed by page 2 should be 24b. Were autopsy tindings available prior to completion of cause of death? 24a. Wes an autopsy performed? 1 ☐ Yes 2 E No 1 ☐ Yes 2 ☐ No certificate Division of Vital funeral director, 25. Was case referred to medical exeminer? 26. Place of Deeth (Check only one) Hospitel: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 1 Yes 2 No this 27. Menner of Deeth 28a. Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Affer 5 Pending investigation To the Hospital or Attending within 24 hours aftar deeth.
To the Funeral Director: Aft completely filled in by the fun 1 TYes 2 No 2 Accident 6 Could not be determined 28f. Location (Street and Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 4 ☐ Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and menner as stated.
2 Medical Examiner: On the basis of examinetion end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner steted. 29e. Certifier (Check only one) 29b. Signeture and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25640 July 13,2000 30. Neme and address of person who completed cause of death (Item 23a) (Type, Print) 1328 Southern Ave., SE, Wash., DC K. Davachi, MD 32. Registrar's Signatu

DHMH 16 Rev 6/95

State Registrar

Please Type or Print In Black Indelible Ink. Assure All Coples Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedant's Name (First, Middla, Last) 2. Data of Death Month CORNELIA 2321 MCGHEE 2000 15 MUN 4b. City, Town, or Location of Death 4a Facility Nama (If not institution, giva street and number) 4c. County of Death RANDALLSTWON NORTHWEST HOSPITAL BALTO. If Under 1 Year | If Under 24 Hrs. Data of Birth (Month, Day, Year) 11-22-1906 Birthplace (Stata or Foreign Country) VA 5. Social Security Number 7. Aga (In yrs. last birthday) Days 1□M 2KF Yrs 94 214-24-3275-A Usual Rasidence of Decedent 10a. Stata 10b. County 10c. City, Town or Location 10d. Inside City Limits MD 1 Ty Yas 2 □ No BALTIMORE RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3829 KILBURN RD 21133 USA 12. Was Decedent Evar in U,S. Armed Forcaş? 1 ☐ Yas 2 ☐ No If Yas, Giva Yaar or Datas: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yas, specify Cuban, Mexican, Puarto Rican, atc.) Race - American Indian, Black, Whita, etc. 1 ☐ Nevar Marriad 2 ☐ Married BLACK 1 Yas 2 No Specify: Specify: 3 XWidowed 4 ☐ Divorced 16a. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highast grada complated) 16b Kind of Business/Industry Elemantary/Secondary (0-12) College (1-4or 5+) TECHNICIAN HEALTH 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middle, Maiden Sumama) HENRY JONES IDA BRANDON 19e. Informent's Name/Ralationship (Type, Pnint) 19b. Meiling Address (Street and Number or Rural Routa Number, City or Town, Stete, Zip Code) GLORIA BRISTOL/CARETAKER 3829 KILBURN RD RANDALLSTOWN, MD. 21133 20b. Place of Disposition (Nama of cematary, cremetory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 1 Burial 2 Cramation 3 Ramoval from Stata MD NAT'L MEM PARK 7/21/2000 LAUREL, MD 4 ☐ Donation 5 ☐ Othar (Specify) hure of Funaral Sarvice Licenses 22. Nama and Addrass of Facility JAMES A. MORTON & SONS F.H., INC Um mes 1701 LAURENS ST. BALTO., MD. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, book, or heert failure. List only one cause on each line. Approximate Interval Between Onset end Death Immediata Causa (Finat disease or condition resulting In daath) CARDOPLUMONARY ARREST Due to (or as a consequence of) CAD Sequentially list conditions, if any, laading to immadiata causa. Entar Undartying Cause (Disaase or Injury that initiated events rasulting in death) Last Due to (or es e consequence of): Dua to (or es a consequence of): Part II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Wes casa rafarred to medical 26. Place of Death (Check only one) 1 Yas 2 No Hospital: Other: 4 Nursing Homa 5 Rasidence 6 Othar (Specify) 1 | Inpatiant 2 | ER/Outpatient 3 | DOA 28a. Data of Injury (Month, Day Year) 27. Menner of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred 1 Netural 5 Panding

sician and bunial-trensit or Attending Physician: The law requires that the deeth certificate be executed Box 68760, attending physician for use as the buria signed by the at d be detached for P.O. Division of Vital Records. page 2 certificate funeral director, this Affer death. e Hospital or Attend n 24 hours after death e Funeral Director:

Physician/Medical Examiner à Completed B edical Certification: To filled In

Physician

/Medical

Examiner

Funeral

Director

28a-f ahow

"natural", or flama 23a or 28a-f ahor adical Examiner must be notified at

pernit. Pages 1 and 2 should be filed within 72 hours effer to Department of Health and Mental Hygiene. Insportant: If item 27 le marked other than "natural", or item eny injury or other traumatic event, the Medical Engine

Physician

/Medical

Examiner

Baltimore, Maryland 21215-0020

deeth

Director

Funeral

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Completed

Be

To

completely within 2 94

State Registrar

DHMH 16 Rev 6/95

30. Nama and address of person who complated cause of death (Item 23a) (Type, Print)

Dr. LUWY J. HARLYAN NWHC 5401 OLD (7. Rd. Pandcullstown, MD 21133 31. Data filed (Month, Day, Year)

29b. Signetura and titla of certifiar

2 Accident

3 Suicida

29a. Certifian

4 ☐ Homicide

(Check only one)

amazotarlan

invastigetion

6 Could not be detarmined

32. Registrar's Signatura

28a. Place of Injury - At homa, farm, street, factory, office building, etc. (Specify)

1 □ Yes 2 □ No

29c. License number

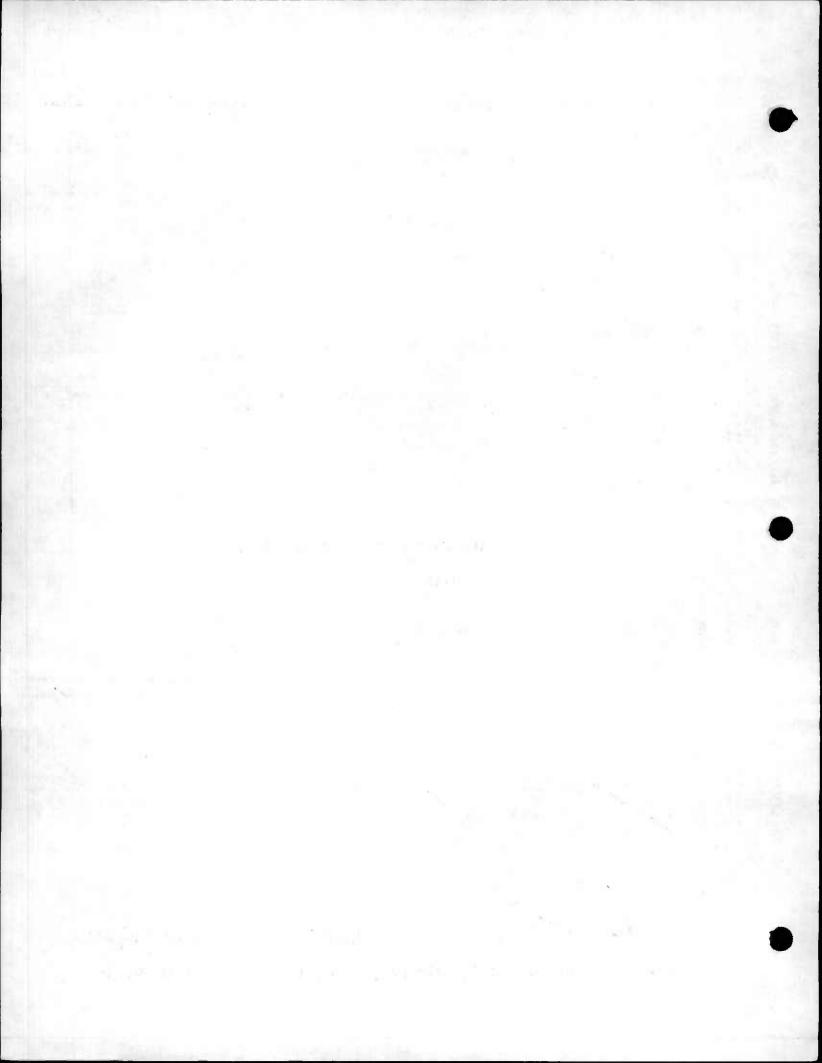
H0051

ORIGINAL

12 Certifying Physician: To the best of my knowledge, death occurred et the time, date end place, end due to the cause(s) end menner es stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date end place, and due to the cause(s) and manner stated. 29d. Data signed (Month, Day, Year)

15,2000

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)



State of Maryland / Department of Health and Mental Hygiene 22468 Certificate of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Deeth Day **Physician** Jacqueline Miller 4b. City, Town, or Location of Death 2000 4c. County of Death Maureen /Medical 10:30 PM 4a Facility Nama (If not institution, give street and number) Examiner 5 Terrace Road Baltimore Essex If Under 24 Hrs. Birthplace (State or Foreign Country) If Under 1 Year 5. Sociel Security Number 7. Age (In yrs. last birthdey) 8. Dete of Birth (Month, Day, Year) **Funeral** Deys Months Hours 1□ M 2√2 F Director 215-54-3759 11/17/1948 Maryland Usual Residence of Decedent the Maryland 10s State 10c. City, Town or Location 10b County 10d. fnside City Limits permit. Päges 1 end 2 ahould be filed within 72 hours after death with the Manylei Department of Heelth end Mentel Hygiene. Important: If item 27 is marked other than "natural", or frema 23a or 28a-f show any injury or other traumatic event, the Headcal Examiner must be notified at page. 1 ☐ Yes 2√ No Funeral Director Maryland Baltimore Essex 10e. Street and Number 10f. Zip Coda 10g. Citizen of What Country? 5 Terrace Road 21221

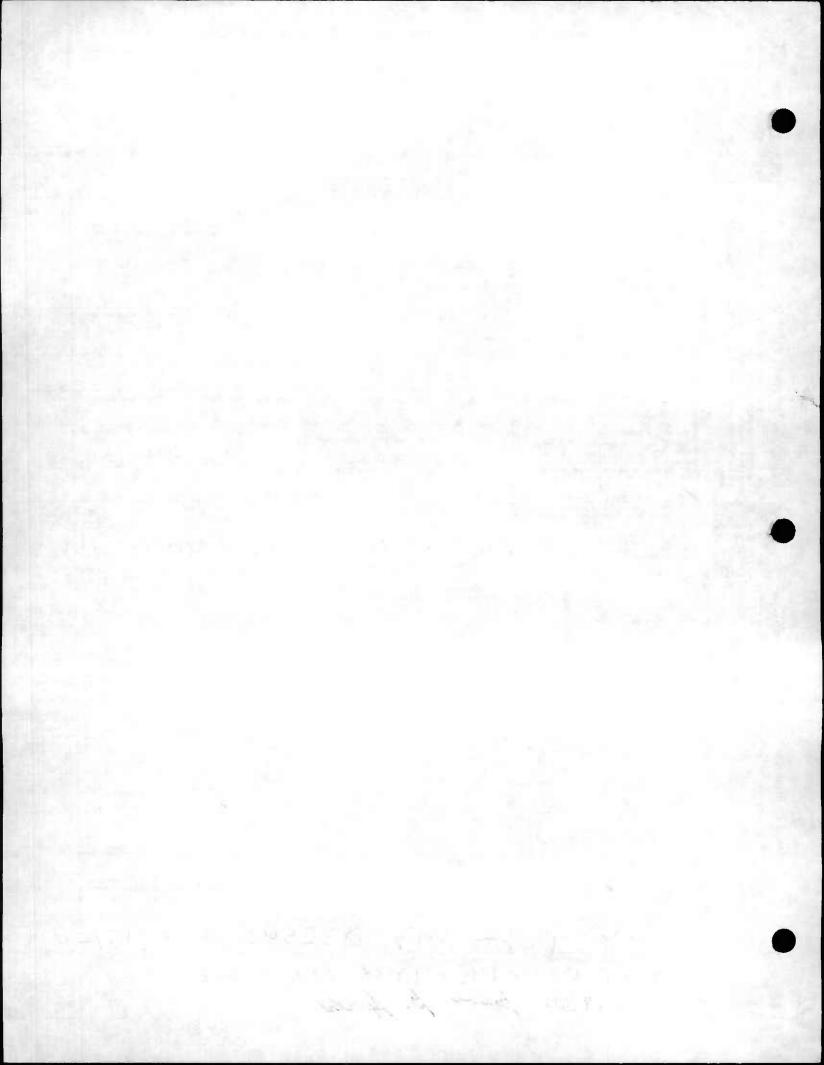
13. Was Decedent of Hispanic Origin? (Specify Yes or Nolf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14. Rece - Amarican Indien, 12. Wes Decedent Ever in U,S. Armed Forces? 11. Maritel Stetus Bleck. White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give X Yeer or Detes: 1 ☐ Never Merried 2 ☑ Merried Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: Completed by 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondery (0-12) College (1-4or 5+) 10 Reporter Newspaper
18. Mother's Neme (First, Middle, Maiden Surname) 17. Father's Neme (First, Middle, Last) Be P Oliver James Josephine Margaret Holiday 19e. Informent's Neme/Ratetlonship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, Stata, Zip Code) 5 Terrace Road Essex, Maryland 21221
Disposition (Name of bete 20c. Location - City or Saville Wilson Miller (Husband) Baltimore, 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20c. Location - City or Town, Stete 20e. Mathod of Disposition 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removal from Stete 4 ☐ Donetion 5 ☐ Other (Specify) 7/15 2000 Green Mount Crematorium Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Bruzdzinski Funeral Home PA 1407 Old Eastern Avenue Essex, Maryland 21221 uchael 23a. Pert1. Enter the disease, or complicators that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or haart failure. List only one cause on each line. Approximete tritarvel Batween Onset end Death **Physician** Lung Cancer Immediate Cause (Finet diseasa or condition resulting in deeth) /Medical 1 year Examiner Physician/Medical Examiner The law requires that the deeth certificate be executed attending physiclen end for use as the burial-transit Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events rasulting in death) Last Due to (or es a consequence of): Box 68760. Due to (or es e consequence of): P.O. ate hes been aigned by the a page 2 should be detached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 WUnknown Division of Vital Records. þ 24b. Wara autopsy findings evaileble prior to completion of cause of deeth? 24a. Wes en eutopsy performed? Completed After this certificate hes 1 ☐ Yes 218No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: After this certific completely filled in by the funeral director, Be 25. Wes cese referred to medical 26. Plece of Deeth (Check only ona) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Homa 5 A Residence 6 ☐ Other (Specify) 1 Yes 2 No Medical Certification: To 28a. Dete of Injury (Month, Dey Year) 27. Mennar of Death 28b. Time of 28d. Dascribe how injury occurred 28c. Injury at Work? if or Attending P 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, office building, atc. (Specify) 4 Homicide 29a Certifier 1x Certifying Physician: To the best of my knowledge, deeth occurred at the time, date end plece, and due to the ceusa(s) end menner es stated.

| Medical Examiner: On the basis of examination and/or invastigation, in my opinion, death occurred at the time, date end plece, and due to the causa(s) and menner stated. 29d. Date signed (Month, Dev. Year) 29c. Licanse number 29b. Signature end title of certifier 00 30. Name and address of person who completed ceuse of death (Item 23a) (Type, Print) H04 Eastern Blvd Esse 21221 ESSEX Md 31. Dete filed (Month, Dey, Year)

JUL 17 2000 32. Registrar's Signeture State Registrar

DHMH 16 Rsv 6/95



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Day **Physician** Lester Hall Miles July 13 2000 11:49 pm /Medical 4b. City, Town, or Location of Death 4a Facility Neme (If not institution, give street and number) 4c. County of Death Examiner Baltimore Greater Baltimore Medical Center Towson 7. Age (In yrs. last birthday) If Under Months If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Dey, Year) Sept. 7 1912 Birthplaca (State or Foreign Country)
 W. Virginia 6 Sax **Funeral** 1 M 2 F Days Yrs. Director 234-10-1418 87 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

ant: If Itam 27 is marked other than "natural", or itama 23a or 28a-f show ury or other traumatic avent, the Medical Evants or must be notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 ☐ No Director MD Baltimore Cockeysville 10a. Street and Number 10g. Citizen of What Country? 300 International Circle 21030 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 □ M'es 2 □ No If Yes, Give Year or Dates: 141-146 Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Meritel Stetus 1X Never Married 2 Married 1 Yes 2 No Specify: Specify. þ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use ratired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Communications Coordinator 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles F. Miles Stella Comba 19a. Informant's Name/Relationship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If Itam 27 Is m any Injury or other trsum page. Richard E. Linder/POA 600 Fairmount Ave., Suite 106, Towson, MD 21286 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremetion 3 Removal from State Odd Fellows Cemetery 7/17/00 4 ☐ Donation 5 ☐ Other (Specify) Clarksburg, W.VA 21. Signatura of Funeral Service Licenses 22. Name and Address of Facility Bryan W. Clary Lemmon Funeral Home 10 W. Padonia Rd., Timonium, MD 21093 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart vailure. List only one cause or each line. Approximete Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): Physician/Medical Examin nding physician and use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury Due to (or es a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably MUnknown signed t þ 24b. Were autopsy lindings available prior to completion of cause of death? Completed 24a. Wes an autopsy performed? 1 ☐ Yes 2 ☑ No 1 Yes 2 No Hospital or Attanding Physician: 24 hours after death.

Funeral Director: After this certifica director. Be 25. Was case referred to medical 26. Placa of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To Inpatient 2 ER/Outpatient 3 DOA 28a. Dete ol Injury (Month, Dey Year) 27. Manger of Death 28c. Injury at Work? 28d. Describe how Injury occurred 28b. Time of 1 Natural 2 ☐ Accident 5 Pending 1 Yes 2 No investigetion 6 Could not be determined 3 Suicide 28l. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pleca of Injury - At home, farm, street, factory, office building, etc. (Specify) 5 4 Homicide

1011 68760 P.O. Records, Division of Vital

Baltimore, Maryland

To the Hospital or within 24 hours aft To the Funeral Di completaly filled in Medical S

State Registrar

29a. Certifier

29b. Signature end title of certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Guaphien 31. Date filed (Month, Day, Year) JUL 17

32. Registrar's Signature

fuarnien, m)

G.Bina

6569 N. Charles

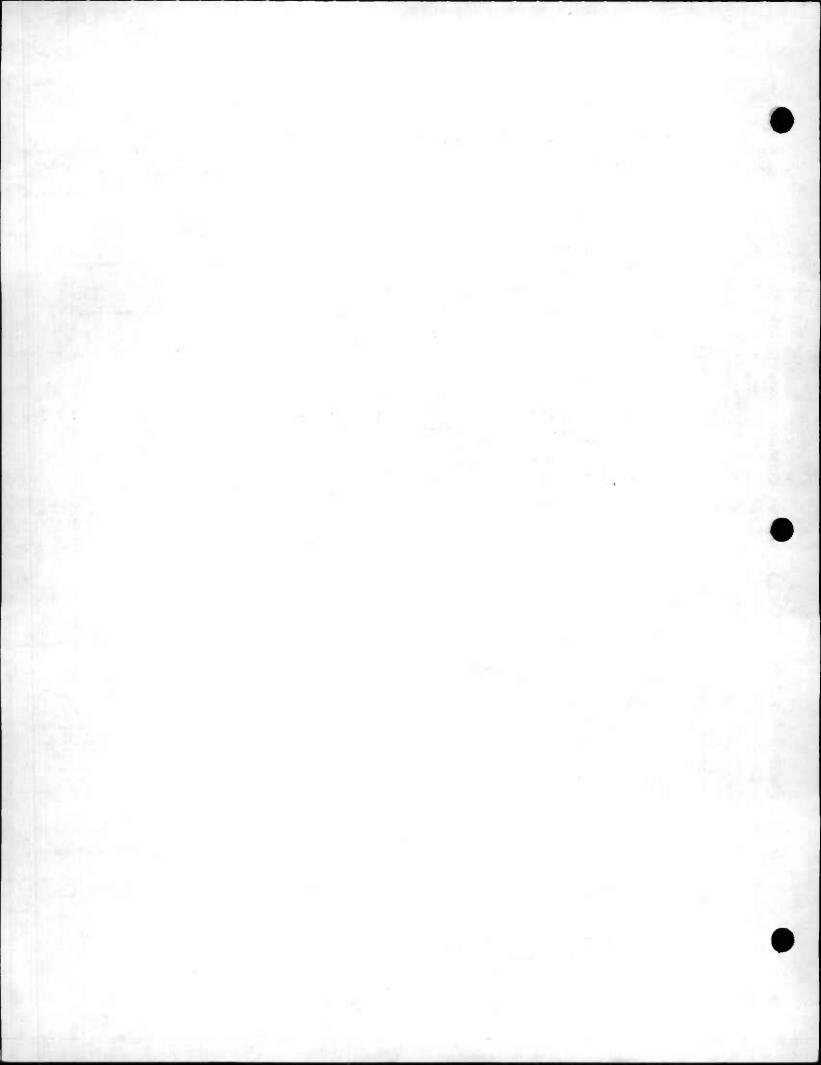
29d. Dete signed (Month, Day, Year)

7-14-07

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the ceuse(s) and menner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and menner stated.

29c. License number



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible.

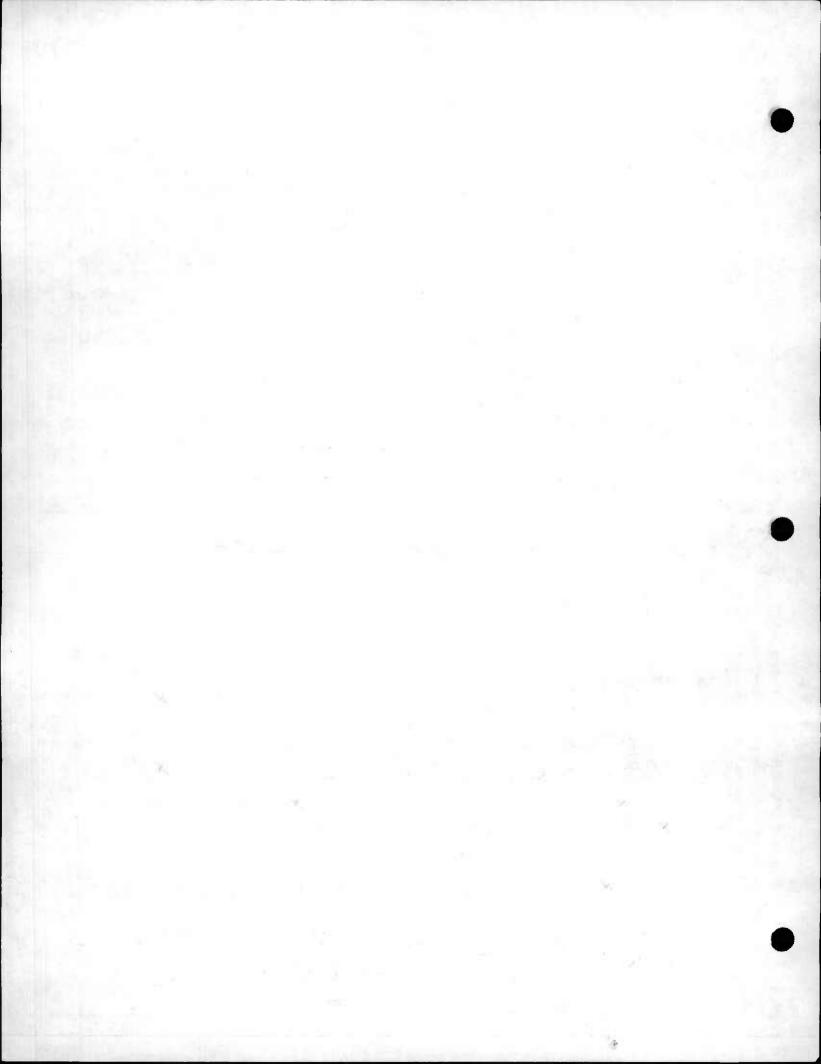
State of Maryland / Department of Health and Mental Hygiene \(\Omega\) Certificate of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 3. Time of Death 2000 Month Physician 13 CONSTANCE PAULINE MARTON July 9:00AM /Medical 4a Facility Nama (If not institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Manor Care Ruxton Baltimore Towson 8. Data of Birth (Month, Day, Year) 5. Social Security Number If Under 1 Yaar If Under 24 Hrs. Birthplaca (Stata or Foreign Country) 7. Aga (In yrs. last birthday) **Funeral** Months Days Hours 1□ M 2X F 84 Yrs. 213-36-7629 November 3 1915 Director Canada Usual Rasidenca of Dacedant 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f ahow traumatic event, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Maryland Towson 10e. Street and Number 10f. Zip Coda 10g. Citizen of Whet Country? 6 234 321 Worthington Road 21286 Canada death Funeral 12. Was Decedent Evar in U,S. Armed Forces? 1 ☐ Yas 2 ☒ No 'natural', or items 13. Was Decedent of Hispanic Origin? (Specify Yas or No-lf Yas, specify Cuban, Mexicen, Puarto Rican, atc.) 14 Race - American Indian 11. Marital Status filed within 72 hours after 1 Nevar Married 2 Married 3altimore, Maryland 21215-0020 1□ Yas 2Ĭ No Specify: à 3 Nidowed 4 Divorced White Yaar or Datas: Completed 16a. Decedent's Usual Occupation (Giva kind of work dona during most of working life. DO NOT use retired) 16b. Kind of Businass/Industry 15. Decedant's Education (Specify only highast grade completed) permit. Peges 1 and 2 should be filed within 7. Department of Heelth and Mental Hyglene. Important: If Item 27 is marked other than "na any Injury or other traumatic event, the Media once. Elamantary/Secondary (0-12) Collega (1-4or 5+) Nurse Medical 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Name (First, Middla, Maiden Surnama) Be Thomas Lawton Gertrude Ormandy 19a. tnforment's Name/Ralationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Routa Number, City or Town, Stata, Zip Code) Baltimore, Maryland 21209 Michael T. Marion 6204 Gernand Road 20b. Place of Disposition (Nema of cematary, cramatory or other place) 20a. Method of Disposition 20c. Location - City or Town, Stata 1 ☐ Burial 2 ACramation 3 ☐ Ramoval from State Green Mount Crematory 7/18/00 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland 21. Signatura of Funaral Sarvica Licensas 22. Nama and Addrass of Facility Mitchell-Wiedefeld Funeral Home, Inc. ottle 6500 York Road Baltimore, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feiture. List only one ceuse on each line. Approximata Interval Between Onset and Death **Physician** Immediata Causa (Final diseasa or condition rasulting in daath) /Medical Examiner Dua to for as a consequence of): Examiner physician and s the bunal-transit The law requires that the death certificate be executed Sequentially list conditions, if any, laading to immediata causa. Enter Underlying Causa (Disease or Injury that initiated avants rasulting in death) Last Dua to (or as a consequence of): Records, P.O. Box 68760. Physician/Medicai Due to (or as a consequence of) Part II. Other eignificant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown signed b þ 24b. Wara autopsy findings available prior to complation of cause of death? Be Completed 24a. Was an autopsy 2 No 1 Yes 1 ☐ Yas 2 ☐ No certificate Division of Vital 05 or Attanding Physician: 25. Was case referred to medical axaminar? 26. Placa of Death (Check only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 tnpatiant 2 ER/Outpatient 3 DOA Certification: To 1 Yas 2 No this 27. Manner of Deeth 28a. Data of Injury (Month, Day Year) 28c. Injury at Work? 28d. Dascribe how injury occurred 28b. Tima of After a Hospitar ...
in 24 hours after deem.
...neral Director: Afte 1 Neturel 5 Pending invastigation 1 Yas 2 No 2 Accident 6 Could not be datarmined 3 Suicida 28a. Placa of Injury - At home, ferm, street, factory, offica building, atc. (Specify) 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 4 Homleide 29a. Cartifier Medicai 🕊 Certifying Phyelcian: To the best of my knowledge, death occurred at tha tima, data and place, and dua to tha causa(s) and manner as stated. completely (Check only 2 Medical Examiner: On the basis of examinetion and/or investigetion, in my opinion, deeth occurred at tha tima, data and place, and dua to the cause(s) and manner stated. To the Within 2 29c. Licensa numbe 29d. Data signed (Month, Day, Year) ed causa of death (Itam 23a) (Type, Print)

DHMH 16 Rev 6/95

State Registrar

JUL 1 5 2000

nei Registrar's Signature



DHMH 16 Rev 6/95

State Registrar 31. Data filed (Month Day Year)

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32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 14, 2000 Physician Edna L. Nelson 12:25pm /Medical 4b. City, Town, or Location of Death 4a Fecility Name (If not institution, give street and number) 4c. County of Death Examiner Baltimore N/A St. Elizabeth Nursing Home If Under 1 Year Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) March 10,1920 If Under 24 Hrs. 7. Age (In yrs. last birthday) **Funeral** Hours Days Months 215-03-9581 80 Yrs MD Director Usual Residence of Decedent with the Manyand 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits itsm 27 is marked other than "natural", or hams 23s or 28s-f show other traumatic event, the Madical Examinar must be notified at FLHernando Springhill 1 ☐ Yes 2 ☒ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 4220 Bayridge Ct. 34606 USA Funeral Wes Decedent of Hispanic Origin? (Specify Yes or No-It Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11 Marital Status 1 ☐ Yes 2 ☑ No If Yes, Give Yeer or Detes: 1 Never Married 2 Married aitimore, Maryland 21215-0020 White 1 Yes 20 No Specify Specify: þ 3 ☑ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Peges 1 and 2 should be filed within Department of Health and Mental Hygiena. Important: If item 27 is marked other than any Injury or other traumatic avenue. Elementary/Secondary (0-12) College (1-4or 5+) Clerk Car Dealership 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Estelle Nowack William Morgan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5200 Larkin Rd. Arbutus, MD. 21227 Gwendolyn Krug, daughter 20b. Place of Disposition (Name of complety, crematory or other place)
Loudon Park Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State 7-17-00 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) Service Lie 21. Signations of Funer 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, MD. 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart feilure. List only one cause on each line. Approximate Interval Between Onset end Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Cancer with 7 month Examiner Examiner attending physician end for use as the burial-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last Due to (or as a consequence of): requires that the death certificate be exec P.O. Box 68760. Physician/Medical Due to (or as a consequence of): Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? be detached 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, þ 24b. Were autopsy findings available prior to completion of cause of deeth? Completed 24a. Was an autopsy Deed certificate has 2 X No 1 Yes 1 ☐ Yes 2 ☐ No 25. Wes case referred to medical examiner? Be 26. Plece of Deeth (Check only one) Hospital: 1 Inpatient 2 ER/Outpatlent 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medicai Certification: To 1 Yes 2 No After this s after deeth.
I Director: After this of in by the funeral d 27. Manner of Death 1 (Delatural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. fnjury st Work? 28d. Describe how Injury occurred or Attending 5 Pending investigation 1 Yes 2 No 2 Accident 281. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plece, and due to the cause(s) and manner es stated.

2 Medical Examiner: On the basis of examinetion and/or investigation, in my opinion, death occurred at the time, date end plece, end due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number MD MINGT 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Center MING Reisterstown Maryland 21136 210 Business Drive 32. Registrat's Signature 31. Date filed (Month State Registrar

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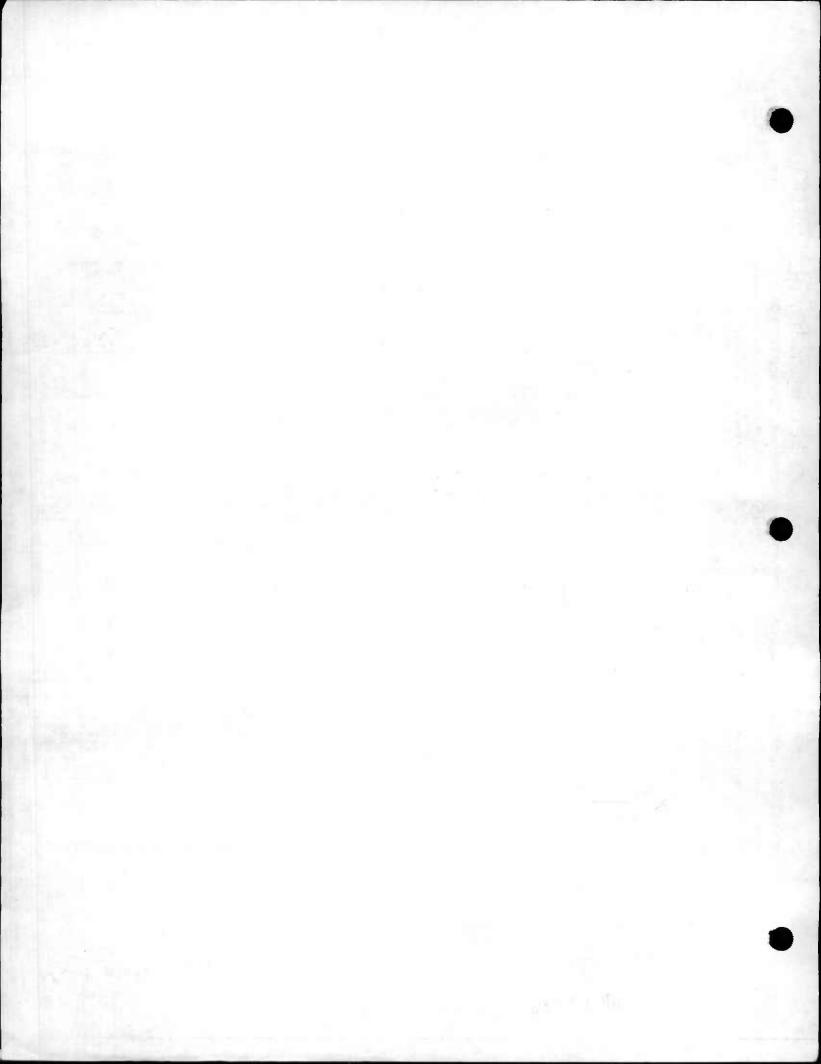
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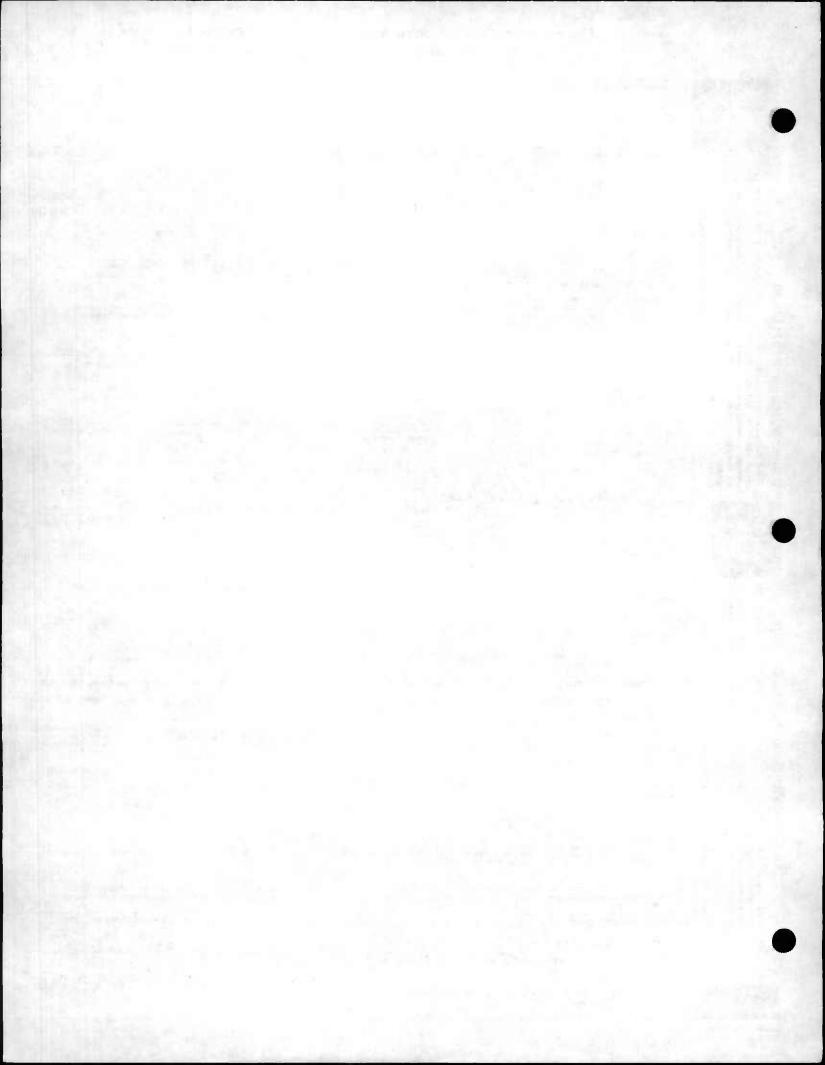
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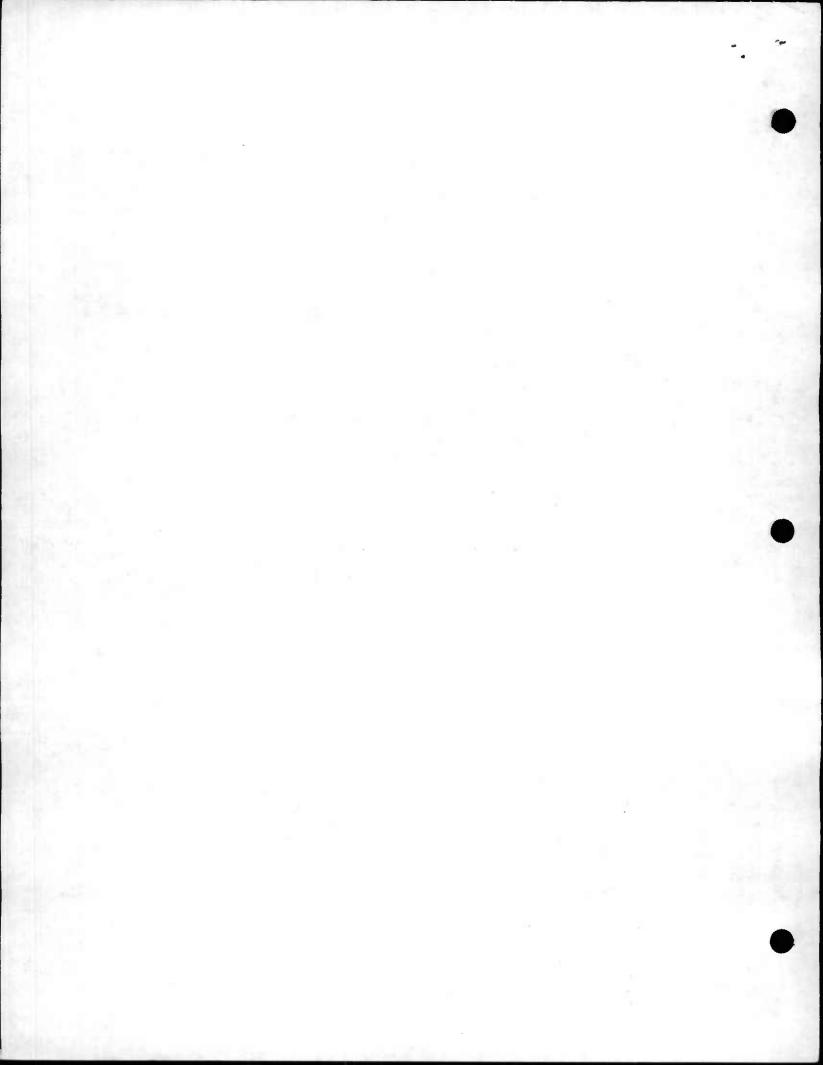
State Registrar

31. Data filed (Month Day, Yaar) 2000 32. Registrary Stonatura



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/Me	sician edical miner	Charlene I 4s Facility Name (II not institution, give	orraine street and number)	Quee	n	4b. City, Town, or L	July	12, 20 4c. County of	00 1:	55am
EXA	mmei	Villa of St. 1			Home	Dalkima				
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dead T	9	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U,S.		of Hispanic Origin? (S Cuban, Mexican, Puert	pecify Yes or No-	14. Race -	American Indian White, etc.	1,
ING KIKI S-UOKO be filed within 72 hours efter death with the Maryland tal hygiene. doubt than 'natural', or items 23a or 28a-f show event, me Medical Examinar must be notified at	by Fu	1 Never Merried 2 Merried 3 Widowed 4 ☑ Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:		1 □ Yes 24□		, , , , , , ,	Specify:	Black	
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Paris E	Ö									
To the Hospital or Attanding Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical Certification:			examination and		he time, date and placa my opinion, death occu				se(s)
thin the	2	29b. Signature and title of artifier	And marinor str		29c J	cense number	. 2	9d. Date signed	Month, Dev. Yes	ar)
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W		30. Name and address of person who	completed eause of d	leath (Item 23a) (Type, Print)	carine A.	n 1/2 20	31 Roll	ings m	121211
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Piease Type or Print in Black Indelibie Ink. Assure Ali Copies Are Legible. 22476 State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Vaar (It-2000 4a Facility Nama (If not institution, giva street and number) 4c. County of Death HOPKIN MORE 101 7. Age (In yrs. last birthday) If Undar 1 Year | If Under 24 Hrs. 5. Social Security Number Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) Days 1₩ 2□ F Months Hours Min Yrs 15 213-55-9013 MD Usual Residence of Decedent 10a Stete 10c City Town or Location 10d Inside City I Imits 10b Count Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2517 Linden Avenue 21217 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - Amartcan Indian, Black, White, etc. 12. Was Decedent Evar in U.S. Armed Forces? Never Married 2 Married 1 Yes 2 No
If Yes, Give
Year or Dates: 1 ☐ Yes 2 ☑ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced Black 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grede completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Infant Infant Infant Infant 17. Fathar's Nama (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown China Robinson 19a, Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kira Sekulow 7911 Tilmont Avenue Baltimore, MD. 21234 20b. Plece of Disposition (Neme of 20c. Location - City or Town, Stata 20a. Method of Disposition Date cemetery, crematory or other place) 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Dohation 5 □ Other (Specify) Parkwood Cemetery 07-17-2000 Baltimore, MD 21. Signature of Funeral Service Lice Baltimore, Maryland 21202 1101 E. North Avenue WM.C.March FH 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting tn death) Sequentially tist conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to for as a consequence of Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Y88 2 No 3 Probably 4 Unknown 24b. Were eutopsy findings available prior to completion of cause of deeth? 24e. Wes en autopsy performed? 2 XNO 20 No 1 Yas 1 Yes 25. Was casa referred to medical exeminer? 26. Place of Death (Check only one) Hospital: Othar: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Impatient 3□ DOA 2 ER/Outpatient 27. Manner of Death Dete of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 5 Pending investigation Injury 1 Natural 1 Yes 2 No 2 Accident

Physician /Medical Examiner cartificate be axecuted

Physician

/Medical

Examiner

Funeral

Director

r than "natural", or itema 23a or 28a-f show the Medical Examinal must be notified at

pemit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiana. Important: If Itam 27 is marked other than "natural", or Itan any injury or other traumatic avent, the Medical Examinas Ross.

Baltimore, Maryland 21215-0020

Director

Funeral

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Completed

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death

Examiner Physician/Medical p Completed Be 2 Certification:

attending physician and for use as the burial-transit Box 68760. P.O. Division of Vital Records. paga 2 s this cartificate has is or Attending Partial after death.

I Director: After to in by the funers filled in by To the Hospital of within 24 hours at To the Funeral D completally filled I

State Registrar

edical

31. Date filed (Month, Day, Year) JUL 1 9 ZUUU

3 Suicide

29a. Cartifier

4 Homicide

29b. Signature and title of certifie

SEPHINE

6 Could not be

28a. Place of Injury - At homa, farm, street, factory, offica building, etc. (Specify)

29c. Licensa number

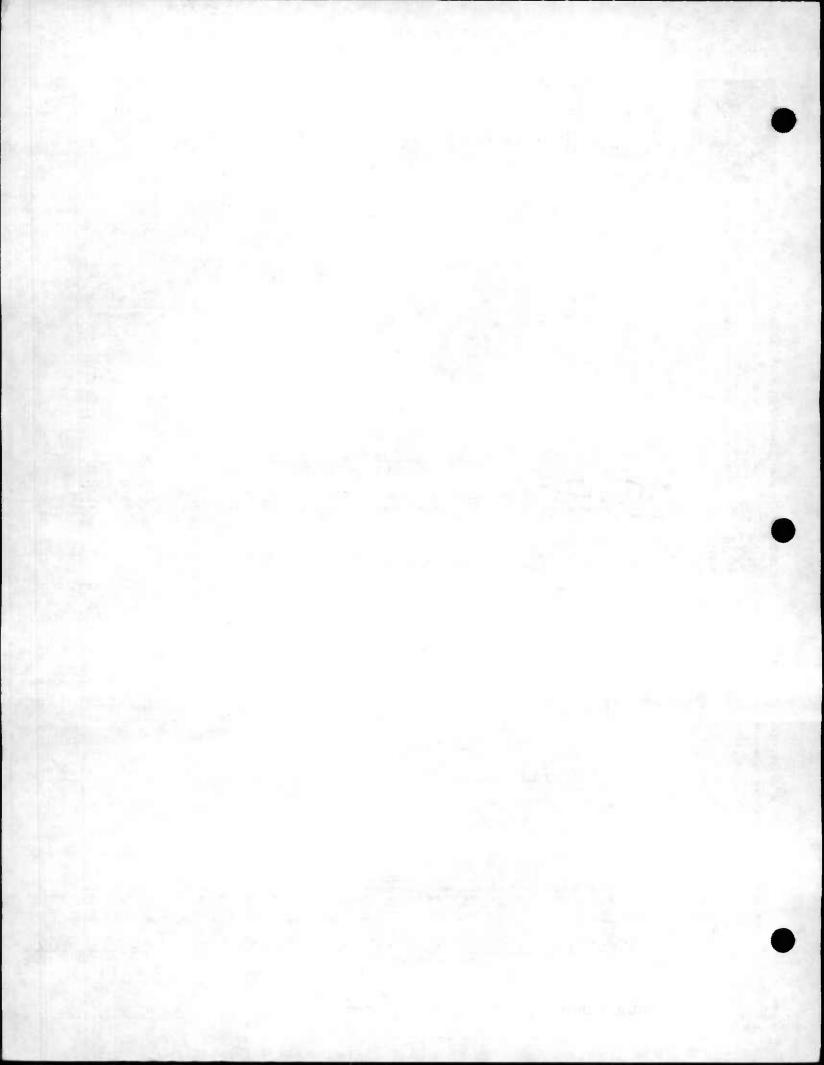
To the best of my knowledge, death occurred at the time, dete end pleca, and due to the ceuse(s) end menner as stated.

Medicat Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, dete and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

281. Location (Street and Number or Rural Routa Number, City or Town, Stata)

30. Name and address of person pleted cause of deeth (Item 23e) (Type, Print)

32. Registrar's Signeture



Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Dete of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Year **Physician** 095/ WILLIAM SMITH, SR 12 00 JOHN /Medical 4b. City, Town, or Location of Death 4a Facility Name (If not institution, give street and number) 4c. County of Death **Examiner** WORCHESTER ATLANTIC GENERAL HOSPITAL

5. Social Security Number 6. Sex 7. Ann Illn vrs. Inc. BERLIN If Under 24 Hrs. 8. Data of Birth (Month, Pay, Year) 9. Birthplace (State or Fo Country) 4-28-1933 MRRY LRND Birthplace (State or Foreign Country) If Under 1 Year 7. Age (In yrs. last birthday) **Funeral** 68 Months Days Hours 1 M M 2□ F Director 216-28-5176 Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Show ?? is marked other than "natural", or itema 23a or 28a-f show traumatic event, the Medical Examiner must be notified at OCEAN CITY 1 St Yes 2 □ No WORCHESTER Director MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number DOB 04/28/1932 117 CHANNEL BUOY ROAD USA Funeral 2/842 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status permit. Peges 1 and 2 should be filled within 72 hours after. Department of Health and Mental Hyglene. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WHITE þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondary (0-12) Coilege (1-4or 5+) FOOD NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 HOWARD M. SMITH CATHERINE A. BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Streat and Number or Rural Route Number, City or Town, Stete, Zip Code) 117 CHANNEL BUOY ROAD/OCEAN CITY, MARYLAND 21842 THERESA SMITH Important: If item 27 i 20b. Place of Disposition (Neme of cematery, crematory or other place) Date 20c. Locetion - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State GARDENS OF FAITH CEMETERY 7/ 15/00 BALTIMORE, MID 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura of Funaral Sarvice Licensaa 22. Nama and Addrass of Facility
ALTENBURG FUNERAL HOME, P.A. ROBERT C. ALTENBURG Poblit G. alterby LIC DO0002 6009 HARFORD RD. BALTIMORE, MD 21214 23a. Parti. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrast, shock, or heart failure. List only one pause on each line. Physician 3 immediate Cause (Final disease or condition resulting in deeth) /Medical 2 DAYS MYOCARDIAL INFARCTION **Examiner** Due to (or as a consequence of): Examiner physician and the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Undarlying Cause (Disease or Injury that initiated events resulting in death) Last Dua to (or as a consequance of): Physician/Medical Due to (or as a consequence of) John Smith signed by the a 23b. Did tobacco use contribute to the cause of death? Part ii. Other significant conditions contributing to death but not resulting in the underlying cause given in Part i. 3 Probably 4 Unknown 1 | Yes 2 | No þ 24b. Were autopsy findings available prior to completion of cause of death? Completed 24a. Was an autopsy parformed? is certificete hes director, page 2 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No Be 25. Wes case referred to medical examiner? 26. Piece of Deeth (Check only one) Hospitai: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Sonpatient 2 ☐ ER/Outpatient 3 ☐ DOA this After this 27. Menner of Death 28d. Describe how injury occurred 28e. Date of injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 5 Pending investigation 1 Natural 12/00 0951 1 Yes 2 No 2 Accident Director: / 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 28e. Place of injury - At homa, farm, street, factory, offica building, etc. (Specify) 4 Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner es steted. edicai 2 Medical Examiner: On the basis of examination and/or investigetion, in my opinion, death occurred at the time, dete end piece, end due to the ceuse(s) and manner stated. (Check only one) To the P within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) H44283 Physician 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Robert Oville 9733 Heritanzy N RoberT

Registrar

State

DHMH 16 Rev 6/95

31. Date filed (Month, Day, Yeer) -

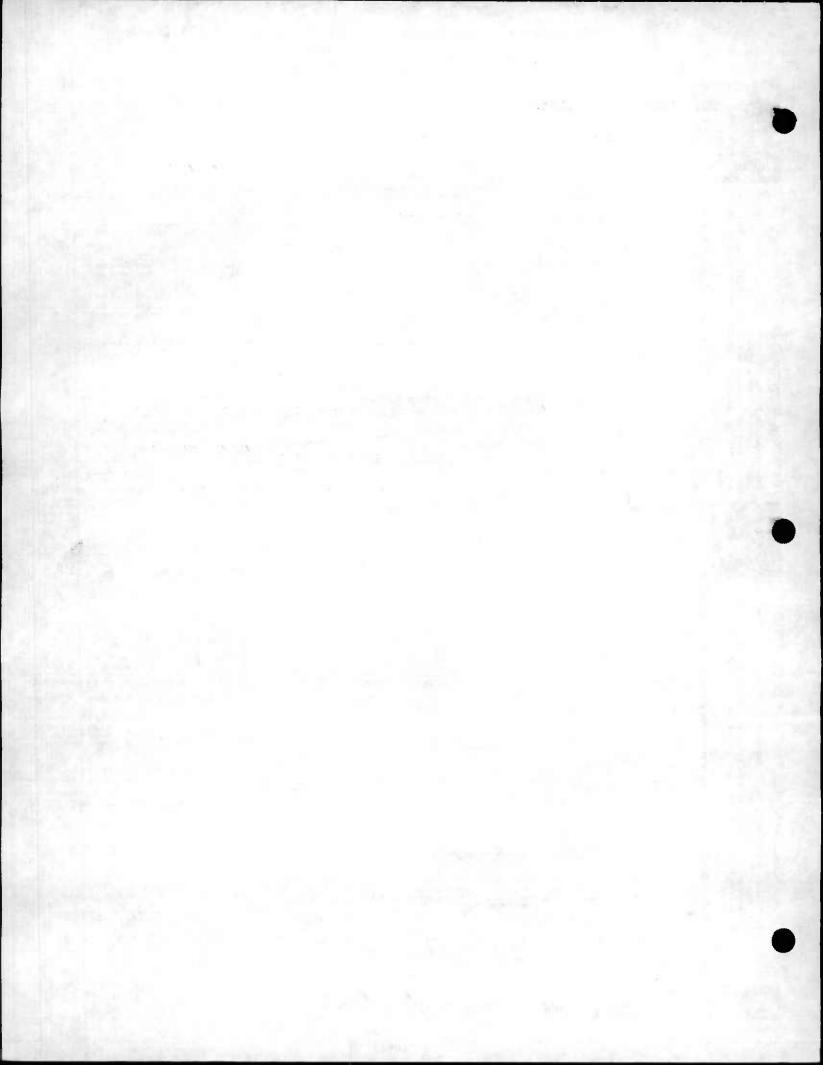
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State of Maryland / Department of Health and Mental Hygiene 00 22478

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To the Functal Director: After this certificate has been signed by the attending physicien and compietely filled in by the funeral director, page 2 ahould be detached for use as the burial-transit or properties of the funeral director. To Be Completed by Physician/Medical Examiner	Sequentially list of any, teeding to cause. Enter Unicause, Chisease of that initiated even rasulting in death. Part If. Other sign Part If. Other sign 25. 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State of Maryland / Department of Health and Mental Hygiene 00 22479

			Certifi	cate of	Death		Re	g. No.			
	1. Decedent's Neme (First, Middle,		Memory 5			2.	Date of Death Month		Year	3. Tima of Death	
hysician /Medical	KAYLA MON	ET SCROE	GINS			M	MARCH	29 2	2000	18:00	
aminer	4a Facility Name (If not institution, THE JOHNS		OSPITAL		4b. City, Ton	wn, or Locat	ion of Death	4c. County	of Death		
ıl r			rrs. last birthday) If	Inder 1 Year	r If Under:		Dete of Birth Month, Day,	Year)	9. Birthpl Coun	ace (State or Foreign (Try)	7
- -	Usuel Residence of Decedent 10a. Stete 10b. County	10c.	City, Town or Location						10	od. Inside City Limits	
Directo	10e. Street and Number) P	9/timore	f. Zip Code	1001		10	g. Citizen of	, -	, (
E	2006 600		Apt. S	di	206		N N	US	, ,		
by Funeral	11. Merital Status 1 Â Never Merried 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	12. Was Decedent Ever in Armed Forces? 1 □ Yes 2 凡 No If Yes, Give Year or Detes:	If Yes	specify Cul	Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Original Hispanic Origin Hispanic Original Hispanic Origina Hispanic Origin	girr (Specir), Puerto Ric	y resor No-		e-America ck, White, o		
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Be Co	17. Father's Neme (First, Middle, La	St)		NIA		or's Neme (F	irst, Middle, M	laiden Sumen	ne)		
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	20a. Method/of Disposition 1 Burial 2 Cremetion 3 4 Donation 5 Other (Spe	Demovel from State	b. Place of Disposition cemetery, cremetor	(Neme of or other pl	ece)	13/	Dete 2	Bolto.	City or To	wn, State	
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	23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications thet caused the dily one cause on each lina.	eeth. Do not enter the	mode of dy		-		-	10	Approximeta Intarvel Between	
an cal	Immediete Causa (Finel disease or condition	FXT	REME F	e Em	ATIL	RITU				Onset end Deeth DAYS	
fedical Examiner	resulting in death)	Due t	o (or as a consequence	- all.	-		LOT	Disi	mo	2 Days	
Examine	Sequentially list conditions, if any, leading to immediate cause. Entar Undertying Cause (Disease or injury	Ų.	o (or as a consequence			<i>V</i> . — .	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	7.50	7 74	2 1/1/3	
Medical	that initieted events resulting in death) Last	Due to	o (or es a consequence	of):							
Physician	Part II. Other significant conditions	contributing to death but not	resulting in the underly	ing cause g	iven in Part I.		23b. Did tol	Dacco use co	ntribute to	the cause of death	?
by Phy	RESPIRA	TORY DIST	RESS 2	SYNE	Rom	E	1□ Ye	8 2 No	3 Prot	ably 4 Unknow	'n
Completed							24a. Was an perform	eutopsy led?	COL	ra eutopsy findings illabla prior to npletion of cause feath?	
							120 Ya	s 2□No	10	Yes 2000	
o Be	25. Wes case retarred to medical examiner? 1 Yes 2 No	Hospitel:	TEDIO terifori, al	7,004 0	ther		Check only one		(04		-
-	27. Manner of Death 1 Natural 5 Pending 2 Accident investigat	28a. Data of Injury (Month, Day Year	28b. Time of	28c. Inje	4U NU	280	5 Reside			9	
Medical Certification:	3 Suicide 6 Could no 4 Homicide detarmine	be On Dian distance	t home, farm, street, for	ectory, office		28f	Location (Str City or Town,	reet and Numl , Steta)	oer or Rura	Route Number,	
edical C	29e. Certifier Certifying	Physician: To the best of my laminer: On the basis of exame and menner steled.	knowledge, death occu	rred et the t ation, in my	ima, data and opinion, daal	d place, and th occurred	dua to the ca at tha tima, da	use(s) and mi	annar as st and dua to	ated. the ceuse(s)	
Med M	29b. Signature and tile of conflier	and menner steted.		29c. Licer	ise number		29	d. Date signe	d (Month, i	Dey, Year)	
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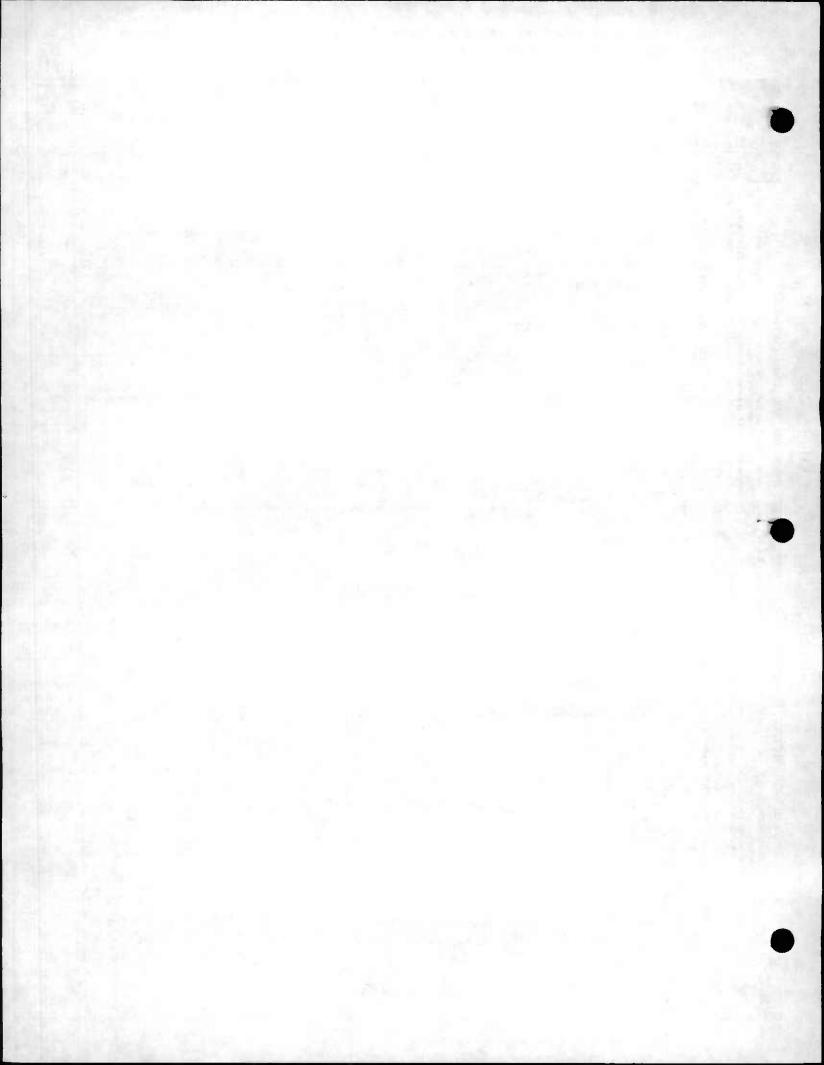
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 3. Time of Death 1. Decedent's Nama (First, Middle, Last) 2. Dete of Death 2000 Physician July 13, AUDREY COSTA SANFORD 9:50 AM /Medical 4c. County of Death 4a Facility Name (If not institution, give street end number) 4b. City, Town, or Location of Deeth Examiner Hospice of Baltimore Gilchrist Center Baltimore Baltimore If Undar 24 Hrs. Hours Min. 8. Dele of Birth (Month, Day, Year) June 12, 1931 If Under 1 Year 5. Social Security Number 6. Sex 7. Aga (In yrs. last birthday) Birthpleca (State or Foreign Country) Funeral Deys 1□ M 2 F Months 216-28-5041 69 Director Md. Usual Residence of Decedent death with the Meryland 10d. Inside City Limits 10a State 10b. County 10c. City. Town or Location 28a-f show mant be notified at 1 ☐ Yas 2 N No **Funeral Director** Harford Bel Air 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or 724 Heston Lane 21014 USA Herns 2 13. Wes Decedent of Hispenic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Wes Decedent Ever in U,S. Armed Forces? 14. Race - American Indian, 11 Merital Status Bleck, White, etc. 1 ☐ Yes 2 1 No If Yes, Giva 1 Never Merried 2 Merried ò Maryland 21215-0020 1 ☐ Yas 2 No Specify: Specify: þ 3 Ø Widowed 4 □ Divorced White Be Completed 16e. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry el Hygiene. Elementery/Secondary (0-12) Collega (1-4or 5+) 12 Secretary Legal 17. Fether's Neme (First, Middla, Last) 18. Mother's Name (First, Middle, Maiden Surneme) Peges 1 and 2 should be in nent of Heelth and Mantel Int: If item 27 is marked or Charles Costa Annabelle Schoelkoph 19e. Informent's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Department of Heelth e Important: If item 27 is any injury or other tra Mr. Gordon A. Sanford, Jr./son PO Box 1521 Freemont, Ca. 94538 Saltimore, 20b. Place of Disposition (Name of cemetery, cremetory or other place) 20c. Location - City or Town, Stete 20e. Method of Disposition Dete 1 ☐ Burial 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Dulaney Valley Memorial 7/17/00 Timonium, Md. 22. Name end Address of Facility Ruck Towson Funeral Home, Inc. 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximata Intervel Between Onset and Deeth Physician Immediate Cause (Final disease or condition resulting in death) /Medical PAS Examiner Physician/Medical Examiner The law requires that the death certificate be executed Sequentially list conditions, if eny, leading to immadiate cause. Enter Underlying Couse (Disease or injury that initiated events resulting in death) Lest and Due to (or es e consequence of): Due to (or as e consequence of) Pert II. Other significant conditions contributing to death but not resulting in the underlying causa given in Part I. 23b. Did tobacco use contribute to the cause of death? P.O. 1 Yes 2 No 3 Probably 4 Unknown þ Records, 24b. Wera autopsy findings available prior to completion of causa of deeth? Completed 24a. Wes an eutopsy performed? pege 2 should 2 No 1 ☐ Yes 2 ☐ No 1 Yas of Vital To the Hospital or Attending Physician: within 24 hours effer deeth.

To the Funeral Director: Affer this certifica completely filled in by the funeral director, it 25. Wes cese referred to medical Be 26. Plece of Deeth (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospitel: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA 1 Yes 2 No Medical Certification: To 28e. Dete of Injury (Month, Dey Year) 27. Menner of Death 28c. Injury et Work? 28d. Describe how Injury occurred Division 5 Pending invastigation 1 X Netural 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28a. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide 29a Certifier 15 Certifying Physician: To the best of my knowledge, death occurred et tha tima, date end place, and due to the cause(s) and menner es stated.

2 Medical Examiner: On the basis of axaminetion end/or investigation, in my opinion, deeth occurred et the time, date and place, and due to the cause(s) end menner stated. 29b. Signature and affe of pertitie 29c. License number 29d. Dete signed (Month, Day, Year) ss of person who completed cause of death/(Item 23e) (Type, Print) N. Chales St. Bolto. md 2120x GBMC 1053 32 Régistrar's Signeture State Registrar

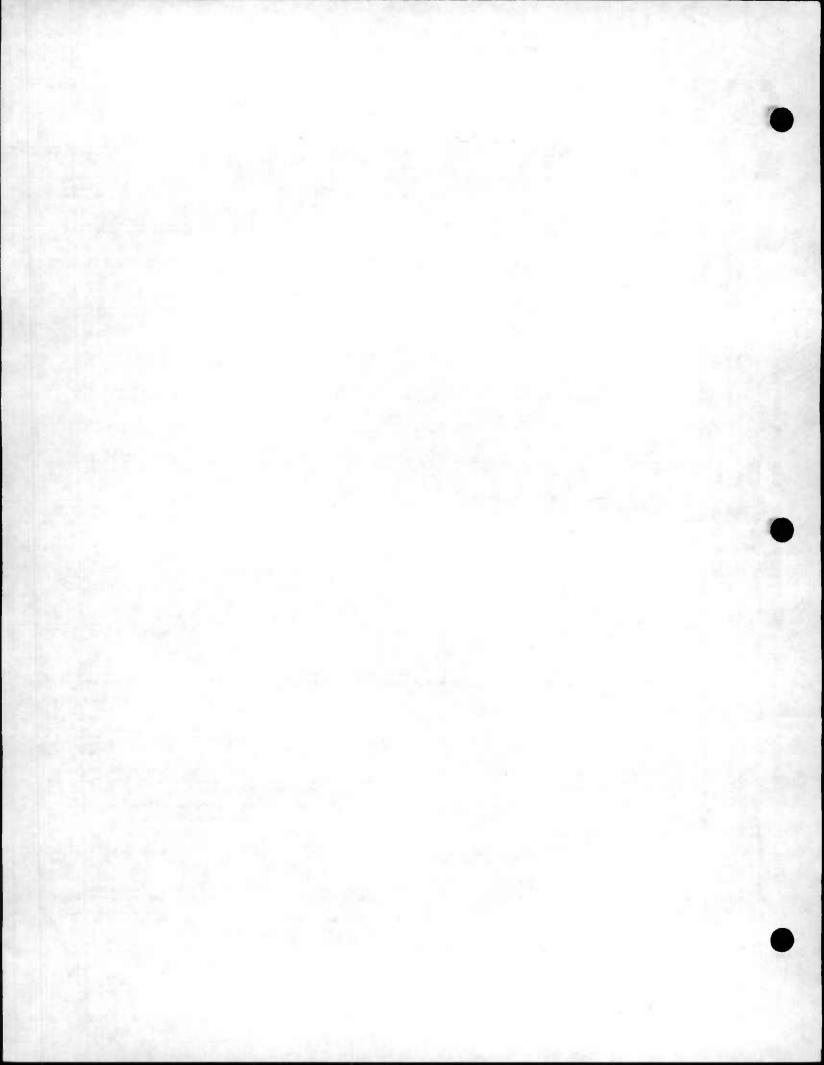
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State of Maryland / Department of Health and Mental Hygiene 0 2248

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Joseph	n G. SCI	haffner	and number				4h City Town	or Location of D	13,	2000 c. County of		MA O
T S H + 1 - 1953				onton				Or LOOZION OF D				
Social Security I	e of Baltim	6. Sex		e (In yrs. las	t birthday)	If Under 1 Yea		Hrs. 8. Deta of	Birth Day, Year,	altimor	e). Birthplace (S	Stete or Foreig
219-01-062 Jsuat Residence		1 X JM 2		81	Yrs.	Months Day	Hours N	11/27/	Day, Year, 1918) N	D.	
IOa. Stete	10b. County			10c. City,	Town or Lo	ocation	13 -2 -				10d. Ins	ide City Limit
MD.	Baltim	ore	MALE	Timon	ium						10	Yes 2 XN
I0e. Street and Nu	nd Number					10f. Zip Code			10g. Ci	itizen of Wh	at Country?	
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1. Maritei Status		An	es Decedent 6 med Forces?		13.	Was Decedent of If Yas, specify Cu	Hispanic Origin? ban, Maxicen, Pi	(Specify Yes or uerto Rican, etc.)	No-		American Indi White, etc.	ien,
	Merried 2 Marr wed 4 Divorced	H Y	Yes 2)() N Yes, Give ear or Detes:	No.		1 ☐ Yes 2 🗓 N	Specify:			Specify:	USA	
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	lame (First, Middle,						3.47	Name (First, Mid		ourneme)		
	A. Schaffner		rint)		19b Maille	ng Address (Stre		Stielper		or Town St	ate Zin Code	
Judith Ulr		aughter)				Harford R			21057	or rown, of		
20a. Method of Dis		augituer)		20b. Plac	ce of Dispo	sition (Name of		Date		ocation - Ci	ity or Town, St	ete
	t 2 Cremation		ai from Stete			matory or other p						
	tion 5 Other (S		a 0	Dular		ley Memor		07/17/2	000 I	imonium	n, MD.	
Separature of P	of Funerel Service	riceusee De	emis C.	Carrol) "	2. Name end Add		Ruck Tows wson, MD.	on Fund 2120	eral Ho 4	me, Inc.	
23a Parti Entar	ntar tha disease, or haert failura. List	complication	s that coused	the death.	Do not ent	tar the mode of d	ring, such as car	diac or respireto	ry errest,		Appro	oximate al Batween
arrenant or Har	ridort (dilord. Elst	only one oed	iou on buon in	ru.							Onsa	t and Daath
Immediate Cause disease or condition	ondition		10	ng	CA	mcer					4	monost
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that initieted event resulting in death)	eath) Last			Due to (or a	s e consec	uence of):						
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ert il. Other eigni	eignificant condition	ons contribution	ng to death bu	ut not resulti	ing in the u	nderlying ceuse	given in Pert I.	23b. I	Did tobacc	o uae contr	ribute to the c	auee of deat
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os Was see	rata want to						40.71			2 No	1 LI Yes	2 No
examiner?	- Same	Hospita	ai:		2/0.	- aC ac . C	Whor:	Death (Check o		· Mari	10-1-1	1
1 Yes 2 27. Mannar of Dea	Death		1 LI Inpatie		VOutpatien 8b. Time o	W 3 DOA	4 LI Nursir	ng Home 5 ☐ F		6 Othar ury occurred		10201
1 Natural 2 Accident	al 5 Pendir		a. Date of tnju (Month, Day	Year)	Injury	N.	ork? ☐ Yes 2 ☐ No			= 11/2		
3 Suicide	de 6 Coutd	not be	e. Plece of Inju	ury - At hom	e, farm, str	reet, factory, offic					or Rurel Rout	e Number,
4 Homicide	cide		building, efc	c. (Specify)				City of	Town, Sta.	ra.)		
29a. Cartifiar (Check only		Examiner: O	in the basis of	examination		h occurred at the vestigation, in my						eusa(s)
	e and little of ceptifie		no manner ste	neu.		29c. Lice	nse number		29d. D	ata signed	(Month, Dey,)	(ear)
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Duta mod [MOI	4 5 2000	Se	NEW TONIE	a. a Signatul	1	B						
(Check only one) 29b. Signeture and 30. Name end add	e and ith of certifie	Examiner: On ar or who complete	n the basis of and manner stee	eath (Item 2	n and/or in	vestigation, in my 29c. Lice	opinion, deeth o	occurred at the ti	me, date ar	nd place, an	(Month, Dey.)	,



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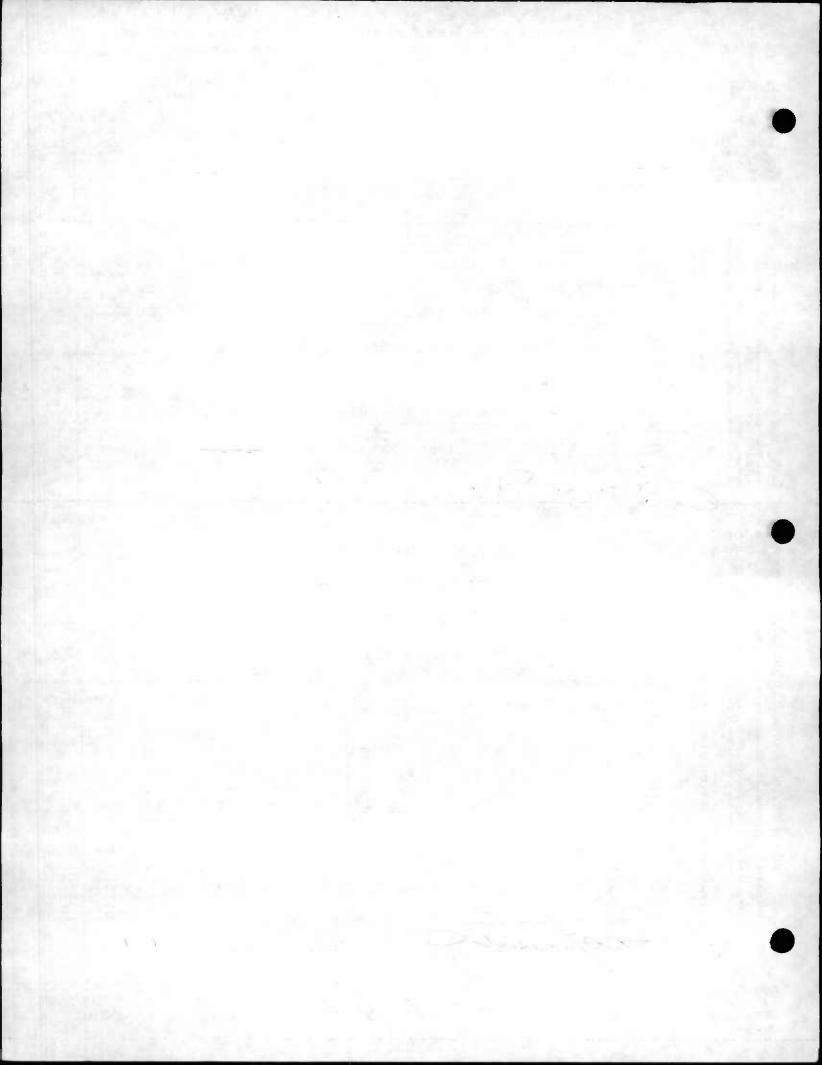
State of Maryland / Department of Health and Mental Hygiene 22482 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** OSCAR L. SMITH 0620 /Medical 4a Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner BALTIMORE V.A. MEDICAL CENTER BALTIMORE NA 7. Age (In yrs. last birthday) | H Under 1 Year | H Under 24 Hrs. | Months | Deys | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** XXM 2 F DC Director 219-58-0381 Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nant of Health and Mentel hygiene.

ant: if Item 27 is marked other than "natural", or items 23s or 28s-f show ury or other traumede event, the Medical Examinar must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits ty Yes 2 No Director Baltimore NA MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Baltimore 611 North Avenue Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Was Decedent Ever in U,S. Armed Forcas? ty Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married 21215-0020 1 Yes 2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) various trades Laborer 10th Grade altimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Smith Helen Henry C. Smith 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21212 19a. Informant's Name/Relationship (Type, Print) 403 E. Northern Parkway Baltimore, Maryland Smith Helen 20b. Plece of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Depertment of H Important: If Its eny Injury or of phos. 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Garrison Forest VA Cem. 07-17-2000 Owings Mills 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licens 22. Name end Address of Fecility Baltimore, Maryland 21202 WM.C.March FH 1101 E. North Avenue 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical 3 WEEKS HEPATIC ENCEPHALOPATH Examiner HERATOCELLULAR CARCINOMA or Attending Physician: The law requires that the death certificate be axecuted Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last HEPATITIS Box 68760, C VIRUS Physician/Medical Due to (or as a consequence of) for use es 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown Completed by 24b. Were autopsy findings available prior to 24a. Was an autopsy performed? completion of cause of death? 20 No this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 89 26. Place of Deeth (Check only one) Hospital: 1 ☐ Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 8 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28d. Describe how injury occurred 28a. Dete of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Attar 5 Pending investigation 1 Natural 2 Accident s after deeth. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide filled in To the Hospital o within 24 hours at To the Funerel D completely filled it Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

**Medical Examiner: On the basis of examination and/or investigation, in my opinion, deeth occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0054734 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A, M.D., VAMHCS, 10 N. GREENE ST., BALTIMORE, MD 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State JUL 1 5 2000 Registrar

sale to me it may the

amended	item 20b per fh g785 7/17/00 ah	Certificate of Deat	h	Reg. No.	
	Decedent's Name (First, Middle, Last)		2. Date of De Month	eath Day Yes	3. Time of Death
nysician Medical	Mary Tucker		7	8 2000	11 1 2 11 13 111
aminer	4a Facility Name (If not institution, give street end number)	4b. City,	Town, or Location of Deat		
	2503 Violet Avenue		altimore		
neral .	5. Social Security Number 220-22-7730 6. Sex 7. Age (In y	Months Days Hour		rth ay, Year) -1926	Birthplace (Stete or Foreign Country) VA
	Usual Residence of Decedent	City, Town or Location			and topide Oits I imite
Examiner must be notified at by Funeral Director		**			10d. Inside City Limits
of o	Ma N/A Ba	ltimore			XXYes 2 No
Funeral Director	10e. Street and Number 2503 Violet Avenue	10f. Zip Code 21215		USA	Country?
6	11. Marital Status 12. Was Decedent Ever in Armed Forces?	n U,S. 13. Was Decedent of Hispanic (If Yes, specify Cuban, Mexic	Origin? (Specify Yes or No.)	0- 14. Race - A Black, W	merican Indien,
2	Widowed 4 □ Divorced	1 ☐ Yas XIX No Speci		Specify:	Black
Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent's Usual Occupation (Give kind of work done during m	ost of working	16b. Kind of Busine	ss/Industry
nor	Elementary/Secondary (0-12) College (1-4or 5+) 9th grade N/A				
O	9th grade N/A	Domestic Worker		Private	Homes
8	17. Father's Name (First, Middle, Last)		ther's Nama (First, Middle		
2			erling Colem		
	19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Addrass (Street and Nur	nber or Rural Route Numi	per, City or Town, State	e, Zip Code)
	Barbara Wilkerson- Granddaught	er 6514 Park Heights		B Baltimo	re, Md
	YYO III ADOMENIA ADOMENIA	b. Place of Disposition (Name of cemetery, crematory or other place) rbutus Memorial Park	7/18/00 7-17-00	20c. Location - City Arbutus, 1	
	21. Signature of Funeral Service Licensee	22. Name and Address of Fe			
8	The way to be	March F/H	West		
-	Ja Part 1. Enter the disease, or complications that caused the d	March F/H 4300 Wabas	h Ave., Ba	ltimore,	Md. 21215 Approximete
arı	shock, or heart failure. List only one cause on each line.	Both. Do not differ the mode of dying, date.	as our side or respiratory		Interval Between Onset and Death
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er	1000thing in Coulti)	ary Artery Diseas	e		1
è		o (or as a consequence of):			
F	0.	c Renal Failure o (or as a consequence of):			
Examine	if any, leading to immediate				
	Cause (Disease or Injury that initiated events	ac Arest o (or as a consequence of):			
edicai	resulting in death) Last	o (or as a consequence or).			
3		sclerosis			
C	Part II Ather algoriticant conditions contribution to double but not	resulting to the underlying source gives in De	22h Dia	I tobacco use contrib	ute to the cause of death?
Physician/	Part II. Other eignificant conditions contributing to death but not	resulting in the underlying cause given in Pe			
	Status Post Coronary	Bypass Surgery	16]Yae 2/€ No 3	Probably 4 Unknown
d by Physic			24a. Wa	s en autopsy 24	b. Ware autopsy findings
Completed				ormed?	available prior to completion of cause
9					of death?
ပိ			10	Yes 200 No	1 ☐ Yes 2 🛣 No
Be	25. Wes case referred to medical examiner?		ace of Death (Check only	one)	
2	1 ☐ Yes 2X No Hospitai: 1 ☐ Inpatient		Nursing Home 5♥ Res	idenca 6 Other (5	Specify)
ation:	27. Mannar of Death 1 Naturai 5 □ Pending (Month, Day Year 2 □ Accident investigation	r) 28b. Time of lnjury at Work? M 28c. Injury at Work? 1 Yes 2		how injury occurred	
ed in by the tuneral	3 Suicide 6 Could not be detarmined 28a. Placa of Injury - A building, etc. (Sp.	At home, farm, street, factory, office ecity)		(Street end Number of	r Rurei Route Number,
2	29a. Certifier 157 Certifying Physician: To the best of my	knowledge, death occurred at the time, date	and place, and due to the	course(s) and manage	r no etetad
edicai	29a. Certifier (Check only one) Certifying Phyeiclan: To the best of my and mannar stated.	nination and/or investigation, in my opinion, o	death occurred at the time	, date and place, and	dua to the causa(s)
completely filled	29b. Signature and title of certifiar	29c. License number	er	29d. Date signed (M	lonth, Dey, Year)
,	TOTE MUNIC	D1763	5	7/11/	0.0
1	30. Name and eddress planson who completed cause of death (
9	Luis A. Mispireta 201	E. University Pk	wv. Ral+i	more Md	21218
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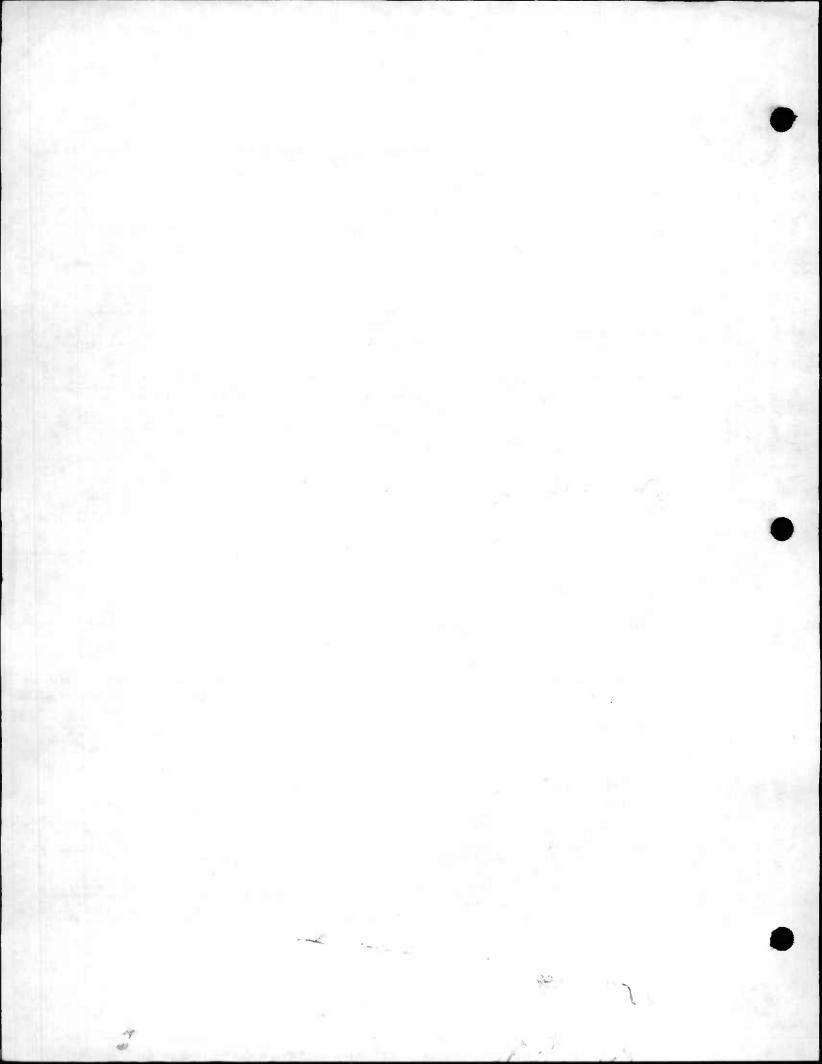


Patient Known As: Joseph Thorn

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Division	
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			Plea			and / Depa		c. Assure A Health and M Death		_		2484	
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	Physician	.1056	ph John	Thorn, I	II				Month July	Dey 12 2	Year 2000	15:01	
	/Medical Examiner	4a Facility Name	-	, give street and no				4b. City, Town, or L Baltimor	ocation of Dea			23102	
	Funeral Director	5. Social Security 213–40–1	Number	6. Sex ↑ M 2 F	7. Age (In	yrs. last birthday) Yrs.	If Under 1 Year Months Deys		8. Date of Bi (Month, Di May 29	av. Year)	Coun	ece (Stete or Foreign try) yland	
-		Usual Residence							riay 2)	, 1941	ria1	yland	_
	how	10a. State	10b. County		10c	. City, Town or Lo	ocation				10	Od. Inside City Limits	
	vith the Ma or 28s-f s be notified	Marylan	1			Baltimo	re					Yes 2□No	
	1 5 7 1 O	10e. Street and No	300(3.0)				10f. Zip Code			10g. Citizen of V			
	E 123	7026 F	ieldcres				2121			United			
21215-0020	permit. Pages 1 and 2 should be filled within 72 hours after death with the Manyland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic avent, the Medical Eseri or must be notified at any holds. To Be Completed by Funeral Director	3 Widowed	rried 2☐ Marri 4 ☐ Divorced	12. Wes Dec Armed F ed 1 Yes If Yes, G Year or I	orces? 2X No ive		Was Decedent of If Yes, specify Cul	Hispanic Origin? (Sp ban, Mexican, Puerto Specify:	pecify Yes or N Pican, etc.)	Bled	e - Americ ck, White, c v: White	etc.	
2-0	led within 72 ho byglene. Ner then "neturi it, the Medical Completed	(904	15. Decedent	's Educetion t grade completed)	1	16a. Dece	dent's Usuel Occu	pation	kina	16b. Kind of Bu	usiness/ind	lustry	
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and	M A OUT	17. Fetner's Name						18. Mother's Nem			10)		
ž	Men di Men	-		norn, Jr.		1		Dorothy					
Maryland	hand hand reun	19a. Informant's h			Danah			ot and Number or Ru				· ·	
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	d de de	Part II. Other sign	ificant conditio	ns contributing to d	eath but not	resulting in the u	nderlying cause g	iven in Pert I.	23b. Did	tobacco use co	ntribute to	the cause of death?	_
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Records,	The law requires that the death certificate beta has been signed by the attending physic page 2 should be deteched for use as the b Completed by Physician/Medical		eral va	scular di	Isease				24a. Wes	s en autopsy ormed?	eva eva	ore autopsy findings nilable prior to npietion of cause deeth?	-
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Ta	antiflor octor,		orred to medical					26. Place of Dee	th (Check only	one)			_
2	Physician: rthis cartific iral director,		No	Hospitel:	Inpatient	2 ER/Outpatie	nt 3 DOA	ther: 4 Nursing H	ome 5 Res	idence 6 Oth	er (Specify)	
0	flar thank		ith 5 ☐ Pending	28a. Dete (Mor	of Injury oth, Day Yea	28b. Time o	f 28c. Inju	ury at ork?	28d. Describe	how Injury occur	red		
S	Attending in death. actor: After by the fune fune fune fune fune fune fune fun	2 Accident	investig	ation			M 1	Yes 2□No					
Division of Vital	tal or Attanding P rs after death. al Director: After t led in by the funer Certification:	3 ☐ Suicide 4 ☐ Homicide	datami	ned 288. Mec	e of Injury - / ling, etc. (Sp	At home, ferm, str ecify)	reet, fectory, office			(Street end Numb own, Stete)	er or Rure	l Route Number,	
	Tana D		1 Contibutor	- Physician To the	- best of our	lander des		Para Mana and ale	4.4	4.	reces.		_
	To the Hospital or Attanding Physiolan: The law within 24 hours after death. To the Funeral Director: After this cartificate has completally filled in by the funeral director, page 2 Medical Certification: To Be Comp	29a. Certifier (Check only one)	2 Medical E	Examiner: On the b and man	e best of my basis of exam uper stated.	ninetion end/or in	vestigetion, in my	time, date and plece, opinion, deeth occur	red et the time	, date end plece,	end due lo	ated. the ceuse(s)	
	Son things		d title of certifier	Mesic	lent	physica	29c. Licen	se number		29d. Date signe	d (Month, i	Dey, Year)	_
	Λ	D /8	ulis	/ Aelol	aid T	ORTIS	RE	5-000	14.3	Sulut	7.2	200	
	12. U-	30. Name and add	lress of person v	who completed cau	se of death (Item 23a) (Type,	Print)				0.[-		-
	No.	Adela	ida Ort:	iz, 2401	W. Be	lvedere	Ave, Bal	timore, M	d. 2121	.5			
	State Registrar	31. Date filed (Mo		2000 32. F	Registrar's S	igneture 4	Sonx						
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State Registrar 31. Dete filed (Month, Day, Year)

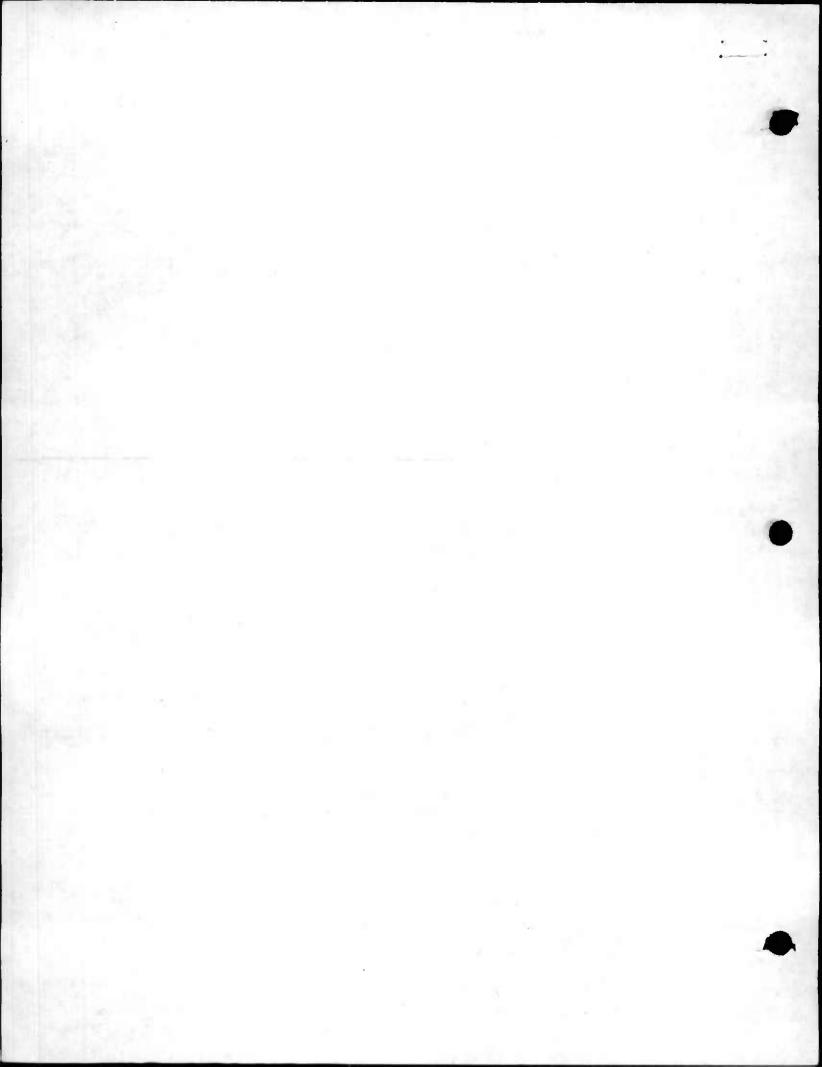
JUL 1 5 2000

David Fowler, M.D. for Stephen Radentz, M.D. Street, Baltimore, Maryland 21201

outos

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

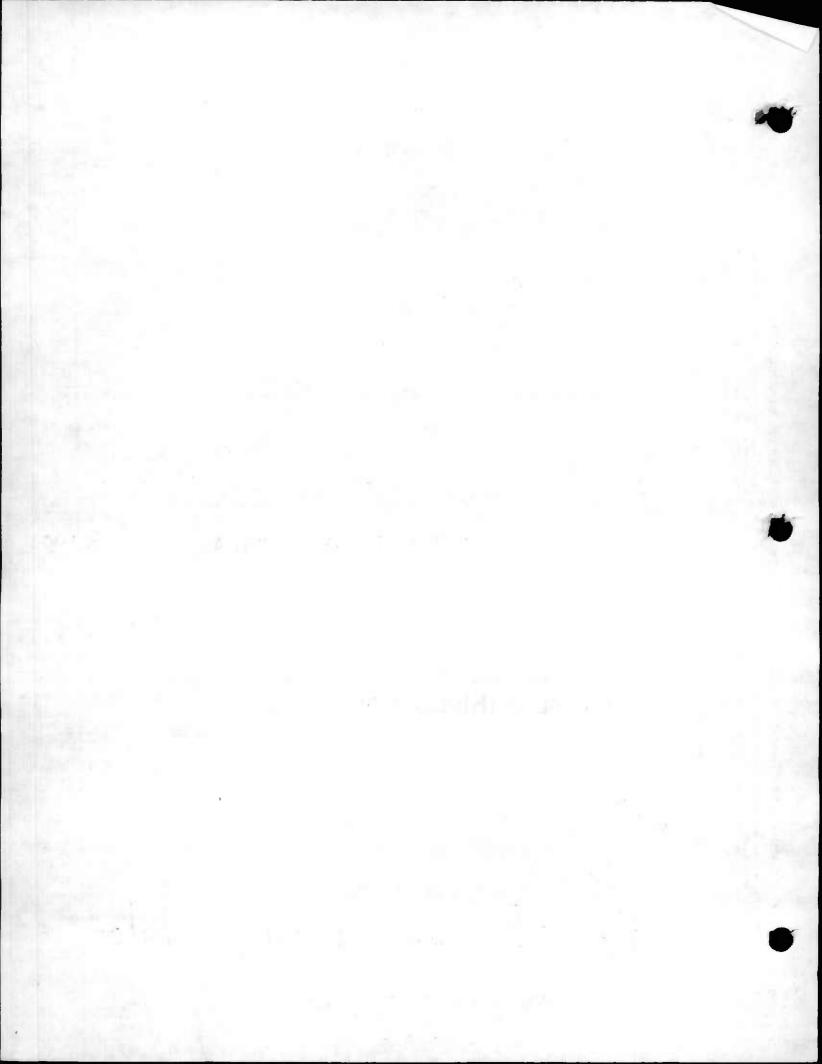
32. Registrar's Signature



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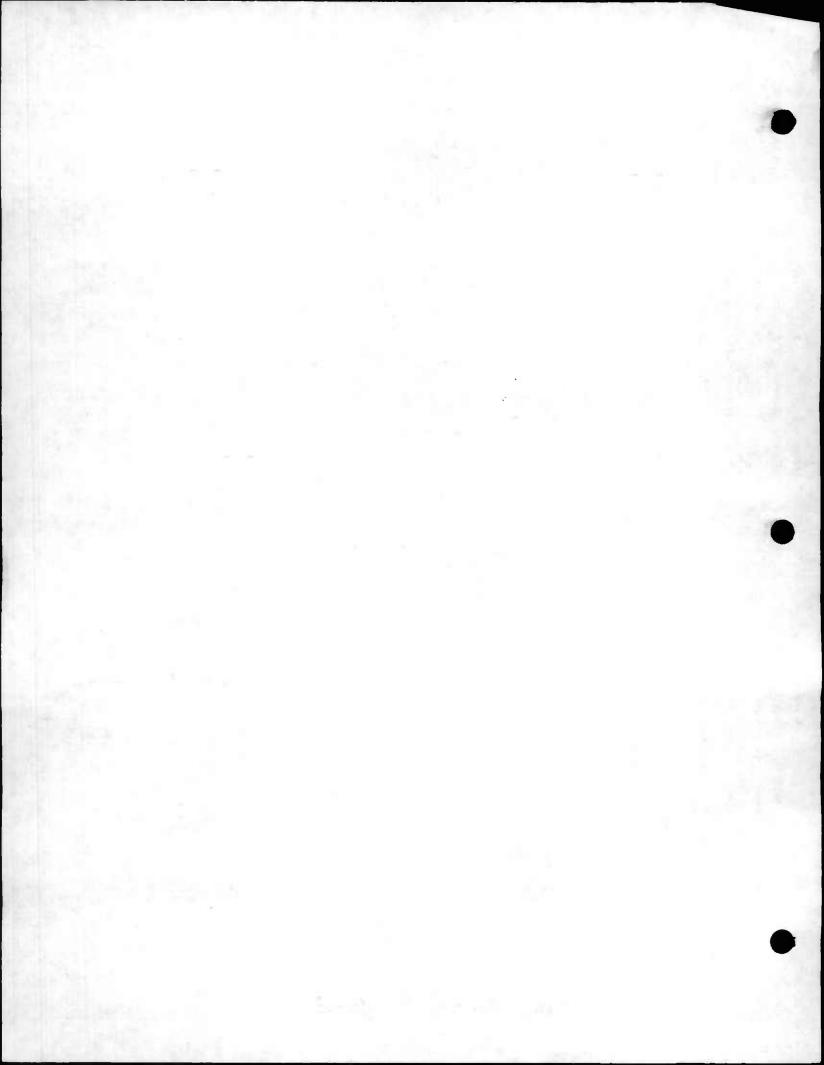
State of Maryland / Department of Health and Mental Hygiene 0 0 224 86

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	1. Decedant's Nama (First, Middla, L	ast)	74-14			2. Date of D	Death Day	Year	3. Time of Death
ysician Aedical	PHILIP	FRANKLIN	WAGLEY			July		000	7:45 P.
aminer	4a Facility Nama (II not institution, gr	va street and number)			4b. City, Tov	vn, or Location of Dec			
	21 Meadow Road				Ba1	timore	Ba1	timor	e
eral			s. last birthday)	If Under 1 Year Months Days	If Under 2	24 Hrs. 8. Data of E Min. (Month, I			place (State or Fore
ctor	094-20-8795	1\\ M 2□ F 83	Yrs.	William Days	riodis		5, 1917	Tex	
2.	Usual Rasidance of Decedent	40-	01b . T	-4*					
ā .	10a. Stata 10b. County		City, Town or Loc					,	10d. Inside City Lim
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2	Evritt Frank	lin Wagley			Lou			xton	
	19a. Informant's Name/Ralationship		19b. Mailing	g Address (Street	and Numbe	r or Rural Route Num	ber, City or Town	, State, Zip	Code)
	Mary Frances Wag			adow Roa	d Bal	Ltimore, M			
	20a. Mathod of Disposition 1 ☐ Burial 2 ☐ Cramation 3 [. Place of Dispos cematery, crem	sition (Nama of natory or other pla	ce)	Data	20c. Location	- City or To	wn, Stata
	4 □ Donation 5 □ Other (Special		reen Mou	int Crema	atory	7-15-2000	Baltime	ore.	Maryland
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1	C 1	Car	Mi	tchell-V	Viedef	eld Funera Baltimon	al Home,	Inc.	21212
	23a. Part1. Enter the disease, or conshock, or heart failura. List only	nplications that caused the de	ath. Do not enta	r tha moda of dvi	no such as	Dal LIIIOI	arrest	rand .	Approximate
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cal	causa. Entar Undarlying Cause (Disease or injury that initiated evants	C	(or as a conseque	anna off:					
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State of Maryland / Department of Health and Mental Hygiene 22487 Certificate of Death 2. Data of Deeth 3. Tima of Death 1. Decedent's Nama (First, Middla, Last) Yaar **Physician** 2:38 AN Venerable D. Wilson July 2000 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Nama (If not institution, give street and number) Examiner Sinai Hospital Baltimore If Undar 24 Hrs. 8. p N/A Birthplaca (State or Foreign Country) If Under 1 Yaar 8. Data of Birth (Month, Pay, Year) 10-22-1918 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Min. Days 1 M 2 F Months Hours 81 Va Director 220-03-0414 Usuel Residence of Decedent 10a. Stata 10c. City. Town or Location 10d. Insida City Limits 10b. County 28a-f show the Medical Examiner must be notified at 1 ♥ Yas 2 No N/A Baltimore Funeral Director Md 10g, Citizan of What Country? 10e. Street and Number 10f. Zio Coda 8 Nems 23a 2205 Wheatley Drive 21207 Α 12. Was Decedanf Evar in U,S. Armed Forcas? 1 1 Yas 2 □ No If Yas, Giva 13. Was Decedant of Hispanic Origin? (Spacify Yas or No-If Yes, specify Cuban, Maxicen, Puarto Rican, atc.) Race - Amarican Indien, Black, Whita, atc. 1 Navar Marriad 2/ Married **Black** 1 Yas 2 No 8 Specify: þ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed Decedant's Usual Occupation (Giva kind of work dona during most of working lifa. DO NOT usa retired) 15. Decedant's Education (Specify only highast grada completed) 16b. Kind of Business/Industry I Hygiena. Elamantary/Secondary (0-12) Collaga (1-4or 5+) Ragan Airport 11th grade N/A Sky Cap 17. Fathar's Nama (First, Middla, Last) 18. Mothar's Nama (First, Middla, Maiden Sumame) of he merital is Be 8 Robert Wilson Esther Belle 19a. Informant's Name/Ralationship (Type, Print) 19b. Mailing Addrass (Street and Number or Rural Routa Number, City or Town, Stata, Zip Coda) Inell Dorothy Wilson- Wife 2205 Wheatley Drive Apt 201 Baltimore, Md 21207 If Item 27 20b. Placa of Disposition (Nama of cematary, cramatory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Stata 6 Burial 2 Cramation 3 Ramoval from Stata 4 ☐ Donation 5 ☐ Other (Specify) Crownsville Veteran Cem 7-17-00 Crownsville, Md 22. Nama and Addrass of Facility 21. Signature of Fuperal Service Licensee March F/H West Baltimore, Md 21215 4300 Wabash Avenue plications that caused the death. Do not enter the mode of dying, such as cerdiac or respiratory errest, one cause on each line. Approximata Interval Batwaan Onsat and Daath **Physician** fmmediata Causa (Final disaasa or condition rasulting in daath) /Medical ancer Examiner Dua to (br as a consequence of): Physician/Medical Examiner use as the burial-transit The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate ceuse. Enter Underlying Cause (Disease or injury that initiated avants resulting in death) Lest pue Dua to (or as a consequence of): P.O. Box 68760. attending physician Dua to (or as a consaquance of): ò Part II. Other significant conditions contributing to death but not resulting in the underlying ceuse given in Part f. 23b. Did tobacco use contribute to the cause of death? 1 Yss 2 No 3 Probably 4 Unknown signed by of Vital Records, þ 24b. Wara autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Be Completed page 2 should has 1 Yas 2 No 1 Yes 2 No certificate or Attending Physician: 25. Was cesa rafarred to medical 26. Placa of Daath (Chack only ona) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) Hospital: 1 Yas 2 No 1 la Inpatiant 3 DOA Certification: To 2 ER/Outpatient this 28a. Data of Injury (Month, Day Year) funeral 27. Mannar of Death 28b. Tima of 28c. Injury at Work? 28d. Dascribe how injury occurred After Division 1 Natural 5 Panding investigation after death. 1 Yas 2 No 2 Accidant the 6 Could not be datamined 28f. Location (Street and Number or Rural Routa Number, City or Town, Stata) 3 Suicide To the Hospital or Atta within 24 hours after de To the Funeral Direct completely filled in by the 28a. Place of Injury - At homa, farm, streat, factory, office building, atc. (Specify) 4 Homicida 1 Cortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. edical 29a, Cartifiar 29c. Licansa number 29d. Data signed (Month, Day, Year) 29b. Signatura and title of certifier RESDOO MD 30. Name and addrass of person who complated causa of death (Itam 23a) (Type, Print) Belvedere Ave Batto, nd Hospit 2 olnai 31. Data filed (Month, Day, Year) 32. Regisfrar's Signatura State JUL 1 7 2000 Registrar



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22488 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Deeth Day Month Year 13 ESTALL Willianson JULY 2000 1.000 4a Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Chapel Hill Nursing Center Randallstown Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Months | Days | Hours | Min. | January 7. Age (In yrs. last birthday) 87 Yrs. 9. Birthplace (State or Foreign 5. Sociel Security Number 17,1913 1□ M 2∯F South Dakota 483-09-4875 Usuel Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore Randallstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4003 Rouen Road 21133 U.S.A 12. Wes Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Reca - American Indien. 11. Maritel Status Bleck, White, etc. 1 Yes 2 No If Yes, Give Year or Detes: 1 ☐ Never Merried 2 ☐ Merried Specify: White 1 ☐ Yes 2 ☑ No Specify 3 ™ Widowed 4 □ Divorced 16a. Decedenl's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementery/Secondery (0-12) College (1-4or 5+) Salesperson Retail Sales 17. Fether's Name (First, Middle, Last) 18. Mother's Neme (First, Middle, Maiden Sumame) Iver A. Heier Amanda Horvey 19e. Informant's Neme/Reletionship (Type, Print) 19b. Meiling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Geraldine Coski (Daughter) 112 Stillmeadow Drive, Joppa, Maryland 21085

20c. Location - City or Town, Stete

Baltimore, Maryland

21/33

2000

14

7017

12000

7/17/00

Physician

/Medical

Examiner

10a. State

Funeral

Director

"natural", or Items 23s or 28s-f show edical Examiner must be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or its any injury or other traumatic event, the Medical Examina

Baltimore, Maryland 21215-0020

P.O. Box 68760.

Division of Vital Records,

Director

Funeral

ğ

Completed

Be

2

20a. Method of Disposition

1 Burial 2 □ Cremetion 3 □ Removel from Stete

of Clar

31. Date filed (Month, Day, Year)

J-Chincus

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

4 ☐ Donetion 5 ☐ Other (Specify)

the Maryland

death with

Physician /Medical Examiner

Completed by Physician/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 bours after death.
To the Funeral Director: After this certificate has been signed by the attending physician and completely filled to by the tuneral director, page 2 should be deteched for use as the buriat-transit completely filled to by the tuneral director, page 2 should be deteched for use as the buriat-transit Be Medical Certification: To

1

State Registrar

21. Signature of Funerel Service Licens	00	22. Name en	d Address of Fecility	ring Rvers Funer	al Directors, In
" Rend	Hag M			, Randallstown,	
23a. Pert. Enter the disease, or compleshock, or heart tellure. List only of	icetions thet caused the dea ne cause on each line.	th. Do not enter the mod	e of dying, such es cardie	ac or respiretory errest,	Approximele Intervel Between Onset and Deeth
Immediate Cause (Final disease or condition	Ga	angreen Lowe	r Extremity		1
resulting In death)	Due to (or as a consequence of):			
	Pe	eripheral Va	scular Dise	ase	
Sequentially list conditions, if eny, leeding to immediate cause. Enter Underlying Cause (Disease or Injury	Due to (or es e consequence of):	7		
thet initiated events resulting in death) Last	Due to (or es e consequence of):			
	d				1
Pert II. Other elgnificant conditions con Dementia			•	1 □ Yee 2 Ø No	ontribute to the cause of death? 3 Probably 4 Unknown
				24a. Wes an eutopsy performed?	24b. Were autopsy findings eveilable prior to completion of cause of death?
				1□ Yes 2☑No	1 ☐ Yes 2 ☑ No
25. Was case referred to medical exeminer?		Tuest	26. Place of Di	eeth (Check only one)	
1 ☐ Yes 2 ☑ No	lospitel: 1 Inpatient 2	ER/Outpatient 3 DC	Other: 42 Nursing	Home 5 ☐ Residence 6 ☐ Oth	ner (Specify)
27. Menner of Death 1 Neturel 5 Pending 2 Accident investigelion	28a. Dete of Injury (Month, Day Year)	28b. Time of Injury M	8c. Injury et Work? 1 Tyes 2 No	28d. Describe how injury occur	rred
3 Suicide 6 Could not be determined	28e. Plece of Injury - At h building, etc. (Speci	nome, ferm, street, fectory	, office	28f. Location (Street and Numi City or Town, Stete)	ber or Rural Route Number,
29a. Cartifier 1 Certifying Physical Check only one) 1 Medical Exami	sician: To the best of my known on the besis of examine end manner steted.	owledge, death occurred etion end/or investigation,	at the time, date and plac in my opinion, deeth occ	ee, and due to the cause(s) end m curred at the time, date end place,	enner es steted. and due to the cause(s)
29b. Signeture and title of certifier		290	. License number	29d. Dete signe	ed (Month, Day, Year)

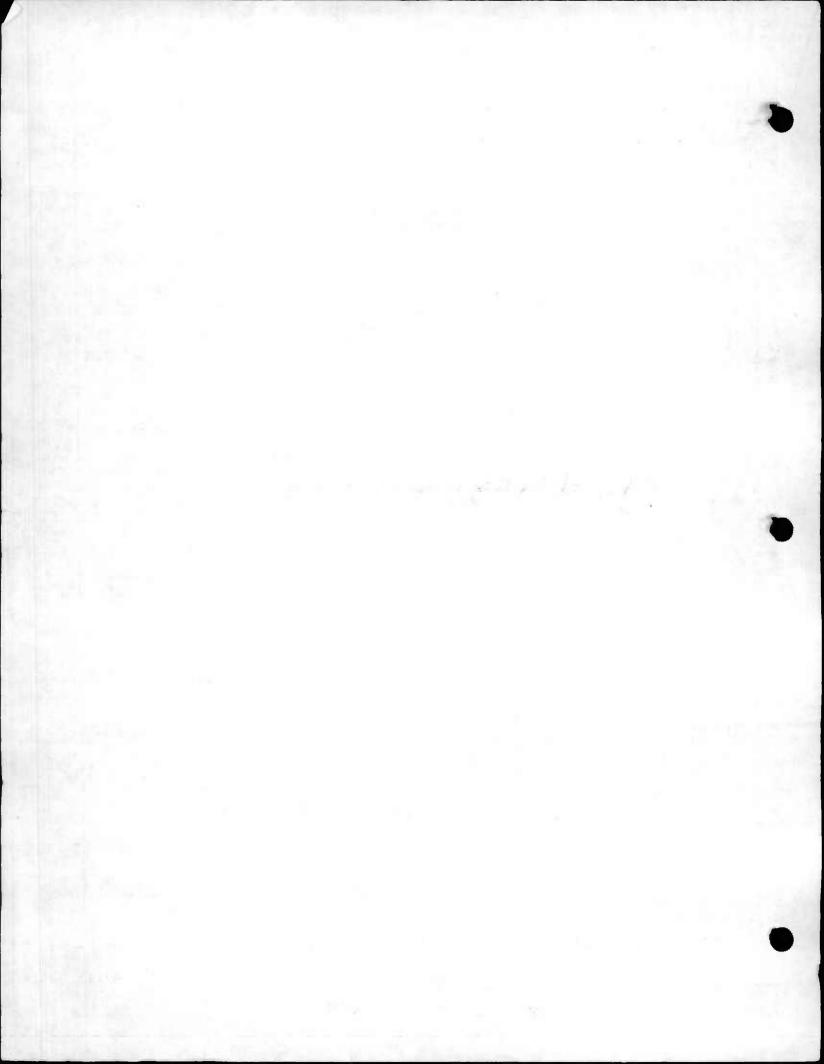
20b. Place of Disposition (Name of cemetery, cremetory or other place)

Most Holy Redeemer Cemetery

DHMH 16 Rev 6/95

5310

32. Registrar's Signeture



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State of Maryland / Department of Health and Mental Hygiene	nn	221.00
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6	MD		NA	В	alti	more					х×	Yes 2□No
8	10e. Streef and Nu				4101	10f. Zip Coo	ie		10g. Citizen	of What Co	untry?	
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ral	2706 B	GLAT				2120		0		USA	rione la #2	
Funeral Director	11. Marital Status		12. Was Decede Armed Force	es?	5. 13	If Yes, specify (of Hispanic Origin? (Cuban, Mexican, Pue	specify Yas or N rto Rican, etc.)	14.	Race - Ame Black, White		arı,
	Never Merr		. If Yes, Give	34		1 □ Yes 2 🛣	No Specify:		Sp	ecify:		
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ete	(Spec		nt's Education est grade completed)		16a. Dec (Giv	edent's Usuat Or e kind of work de	ecupation one during most of wo stired)	orking	16b. Kind	of Business/	industry	
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Completed	10th G		NA		one	mploye		480		emplo	yea	
Be	17. Father's Name						18. Mother's Na	ame (First, Middl	le, Maiden Sui	mame)		
2	Stanle	У	White,	Sr.			Phyl:	lis	Gil	lis		
once. To	Phylli 20a. Method of Dis 1⊠ Burial 2 4 □ Donetion	S position □ Cremation	Gillis 3 Removal from St	ate	270 lace of Disp emetery, cr	06 Bery position (Nama of ematory or other	place)		imore,	Mary ion - City or	ylan Town, Sta	ite
puce.	21. Signature of Fo	aneral Service	Licensee CO	N	1	WM.C.Ma	ddress of Facility	Baltin 1101 E.	nore, Nort	Mary!	land	2120
n al	Immediate Cause disaese or condition	(Final	r complications thet cau t only one cause on eac BLUNT	used the death ch tine. FORCE	INJU		dylng, such es cardie HEAD AND				Interva	ximate at Between and Deeth
	resulting In death)			Due to (or	es e cons	equance of):	10	1,12.3				
ai Examiner	Cogunatiathy list or	nditions	b	Due to for	as a cons	equence ol):	+ -					
	Sequentially list co if any, leading to ir cause. Enter Undo Cause (Disease or	nmadiata erlying		5.0 (0)	30 to 000 101							
n/Medical	that initiated event resulting in death)	5	d	Dua to (or	as a conse	equance of):						
Physician/Me	Part II. Other signi	ficant conditi	one contributing to deal	th but not resu	ılting in tha	underlying caus	e given in Part f.		d tobacco ua			
	-							24a. Wa	as en autopsy	24b.	Were auto	opsy findings
8								Det	nomear			
Completed by									rlormed? ☐ Yes 2☐ l			n of cause

To the Hospital or Attending Physicie within 24 hours after deeth.

To the Funeral Director: After this cert completely filled in by the funeral direct Division of Vi

Medical Certification: To

1 Yes 2 No 27. Menner of Death 1 Netural 2 Accident

29a. Certifier

3 ☐ Suicide 4 ☐ Homicide

Pending اُسْرُ 5 nvastigation 6 Could not be determined

Hospital: 1 ☐ Inpatiant 2 XER/Outpatient 3 ☐ DOA 28a. Date of tnjury FOUMORD, Day Year) 28e. Place of Injury - At home, lerm, street, factory, office building, etc. (Specify)

28b. Time of Found:

A 28c. tnjury at Work? 1 ☐ Yes 2 No

O.C.M.E.

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28d. Describe how injury occurred SUR IFCT SUSTAINET BLUNT FORCE INJURIES AND WAS ASPHYXIATED

281. Location (Street and Number or Rurel Route Number, City or Town, State) 6000 ERDMAN AVE. BALTIMORE, MD

July 10, 2000

1 Certifying Physician: To the best of my knowledge, death occurred at the time, dete and place, end due to the cause(s) and menner as stated.

Medical Examiner: On the basts of examinetion end/or investigation, in my opinion, death occurred at the time, date end place, end due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and fitte of certifier

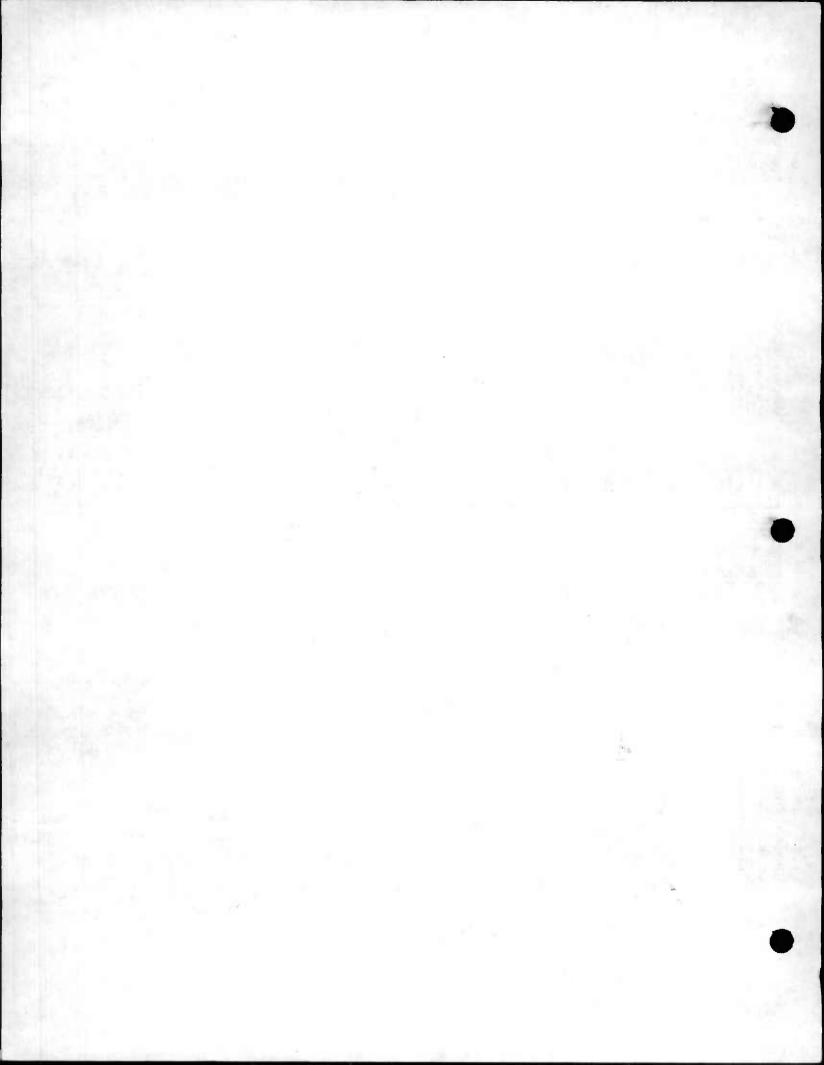
30. Nama and address of person who completed cause of death (Item 23a) (Type, Print)

Min. 1,11 Penn Street, Baltimore, Maryland 21201

TEAMSTERS HALL

State Registrar

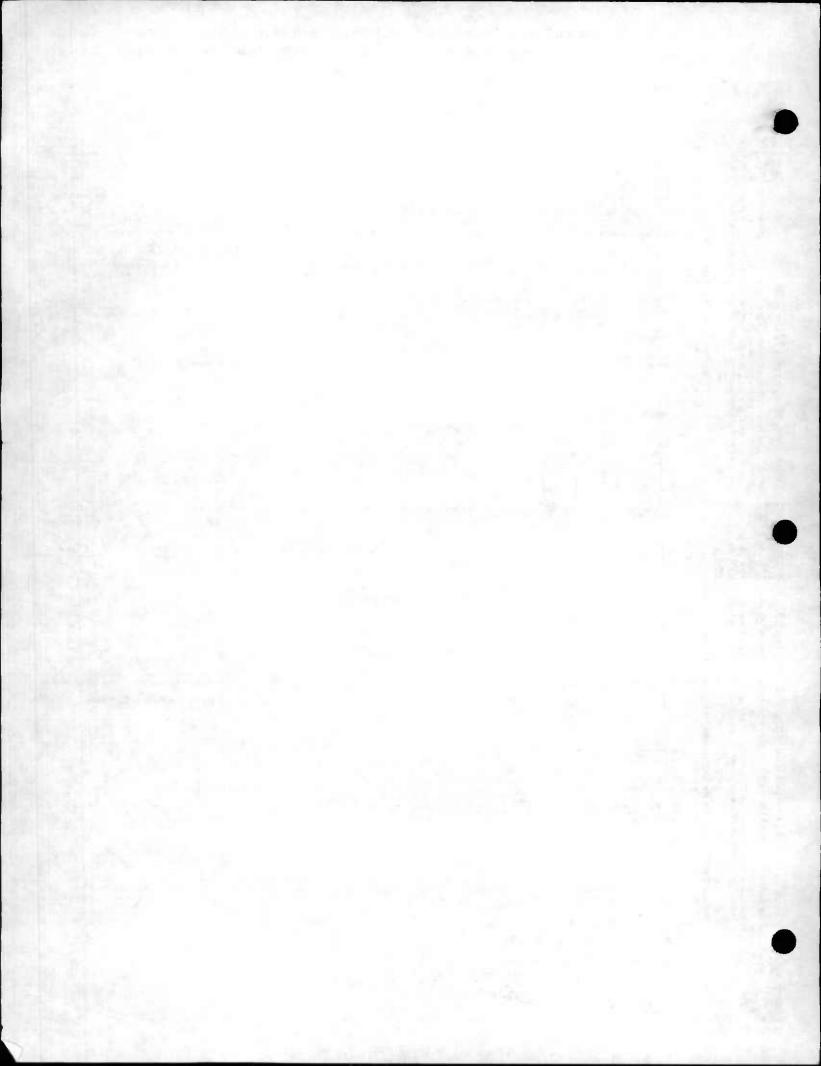
31. Date filed (Month, Day, Year) 72. Registrar's Signeture



State of Maryland / Department of Health and Mental Hygiene 0 22490

					Ce	rtificat	e of	Death			Reg. No.		Nette Invest 8 6	
Philippin	1. Decedent's Neme									2. Date of De Month		Yea	ar	ot Death
Physician Medical	Dona	ald Earl 2	Zealor							July	12	2000 Yes	11:1	LOPM
Examiner	4a Facility Name (If n		e street end nu	umber)				4b. City, To Towsol		ocation of Deat		County of D		
Funeral	5. Social Security Nun 216-24-8193	nber 6. S	Sex 10XM 2□ F		s. last birthday, Yrs.	If Under Months		If Under Hours		8. Date of Bir (Month, De July 12		9.1	Birthplaca (Stete Country) aryland	or Foreign
Director	Usual Residence of D	ecedent		71	110.				*	July 1	192	.9 1/16	rylanu	
with the Maryland a or 28a-f show the notified at Director	10a. State 1	Ob. County Baltimore			City, Town or L 11 timore	ocation							10d. Inside 1 ☐ Ye	City Limits
or 25s-f s be notified Director	10e. Street and Numb	per				10f. Zip	Code				10g. Citiz	zen of What	Country?	
at he o	3108 Gard	en Ave.				1	21234					USA		
her death v iner must funeral	11. Marital Stetus		12. Was Dec	cedent Ever in	U,S. 13.	Wes Deced	dent of I	Hispenic Ori	gin? (Sp	ecity Yes or No Rican, etc.)	-		merican indian, /hite, etc.	
Exer.	1 Never Married 3 Widowed 4			2□No Ko	prean	1□ Yes		Specify:				Specify:	White	
od within 72 ho yglene. we then "natur 4, the Medical. Completed	(Specify	5. Decedent's E	ducation ade completed,)	(Give	dent's Usua kind of wo	rk done	during mos	t of work	ing	16b. Kii	nd ot Busine	ss/Industry	
within then the Me	Elementary/Second	lary (0-12)	College	(1-4or 5+)	Carpe	DO NOT u	se retire	d)			Con	structi	ion	
	17. Father's Name (Fi	irst, Middle, Last)		Carpe	III		18. Mothe	er's Nem	e (First, Middle			1011	
Mental H whental H writed off allo ever	James Z	ealor						Flor	ence	Burton				
and Name	19a. Intermant's Nam	e/Relationship (Type, Print)		19b. Mail	ing Address	(Stree	t and Numb	er or Rur	al Route Numb	er, City o	r Town, Stel	e, Zip Code)	
and 3 n 27 in wer tra	Mrs. Bertha		ife					e. Bal	timor	e, Md. 2				
f of H ff Her or off	20a. Method of Dispos		Removal trom		Place of Disp cemetery, cre	osition (Ner metory or o	ne of other ple	ice)	i	Dete	20c. Lo	cation - City	or Town, State	
eenit. Pages 1 a Apartment of Hea mportant: If Item ny Injury or othe EGS.	4 □ Donation 5		The same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the same of the sa	M	oreland_			4 500 141		-15-00	Parkv	ille, N	1d.	
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	23a. Part1. Enter the shock, or heart	disease or com	unications that	caused the de	ath. Do not en	iter the mod	le of dy	ng, such as	cardiac	or respiratory	rrest,		Approxim	ete
Physician					32.7				- /				Onset an	d Death
/Medical Examiner	Immediate Cause (Fi disease or condition resulting in death)	nal	a	Acute	· M,	Mere	loge	wous	6	enkern	a		1/24	he.
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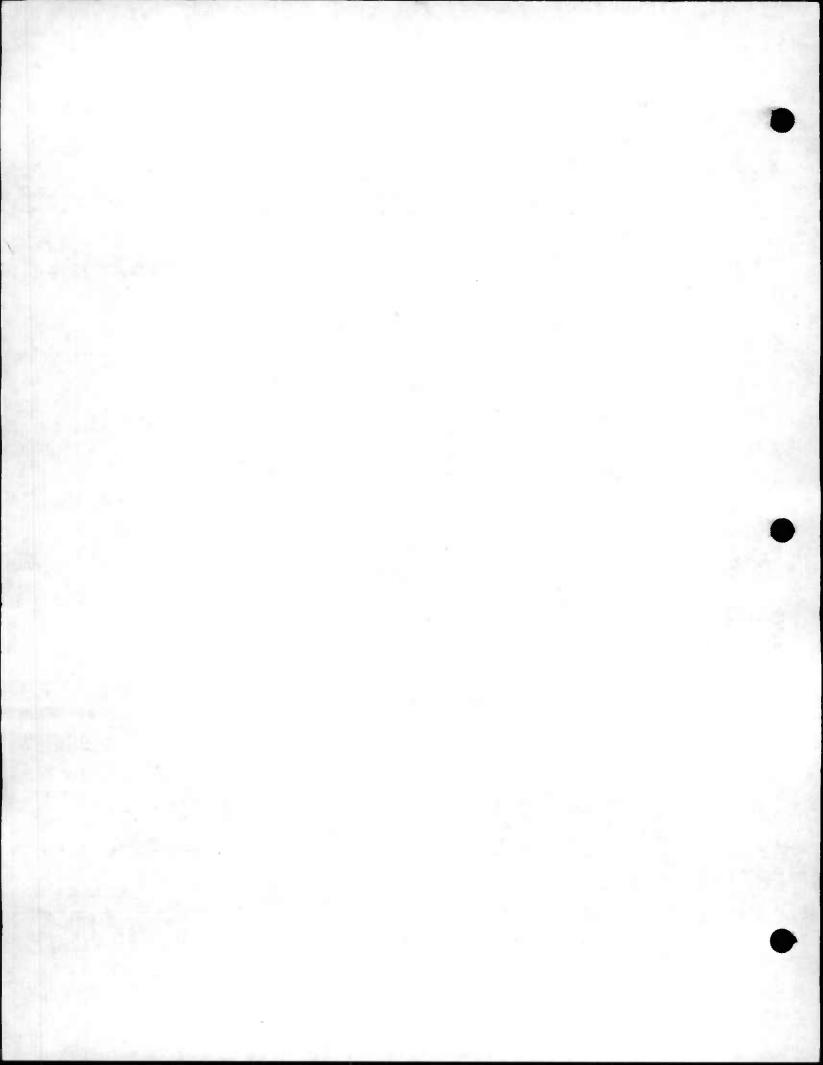
DHMH 16 Ray 6/95



State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Dete of Death 3. Time of Death 1. Decedent's Neme (First, Middle, Last) Day Month **Physician** July 3 2000 06:45PM RENSHAW **ADAMS** /Medical 4e Facility Name (If not Institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner White Plains 4680 Pickeral Street Charles | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Min. | Min. | June 18, 1915 5. Social Security Number 7. Age (In yrs. last birthdey) 9. Birthplece (State or Foreign **Funeral** 1□M 20X 213-09-6773 Virginia Yrs. Director **Usual Residence of Decedent** permit. Peges 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health end Mental Hygiena. Important: If Hem 27 is marked other than "natural" or the traumatic average in the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control of the control 10a. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 27 No MD Funeral Director Charles White Plains 10e Street and Number 10f. Zip Code 10g. Citizen of Whet Country? 4680 Pickeral Street 20695 USA Wes Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuben, Maxican, Puerto Rican, etc.) Rece - American Indien, Bieck, White, atc. 11. Meritel Stetus 12. Was Decedent Ever in U,S Armed Forces? 1 Yes 2 No
If Yes, Give
Yeer or Detes: 1 Naver Married 2 Merried 1□ Yes 2 No Specify: Specify: White Be Completed by 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuet Occupetion
(Giva kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementery/Secondery (0-12) Coilege (1-4or 5+) Proof Reader Banking 18. Mother's Neme (First, Middle, Maiden Sumeme) 17. Father's Neme (First, Middle, Last) Levin Hiriam Fisher Betty Alice Thomas Fisher 19e. Informent's Neme/Reletionship (Type, Print) 19b. Mailing Address (Street end Number or Rurel Route Number, City or Town, Stete, Zip Coda) Myrtle Skinner/Daughter P.O. Box 613 White Plains, MD 20695 20a. Method of Disposition 20b. Pieca of Disposition (Neme of cemetary, cramatory or other plece) 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removet from State 4 ☐ Donetion 5 ☐ Other (Specify) Nanjemoy Baptist 7/7/00 Nanjemoy 21. Signeture of Funerel Service Licensee 22. Name and Address of Fecility
AREHART-ECHOLS FUNERAL HOME M00945 567 LA PLATA, MD. 20646 P.O. BOX 23a. Partf. Enter the disease, or complications that caused the deeth. Do not anter the mode of dying, such es cardiac or respiratory errest, shock, or heart feiture. List only one ceuse on each line. Approximete Intervat Batwaan Onset end Daath **Physician** Gastric Carcinon /Medical Immediata Ceuse (Finei disease or condition rasulting in deeth) Stomach Cancer Examiner Due to (or as e consequence of) Examiner The law requires that the deeth certificate be asscuted attending physician and for use as the buriel-trens Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disaese or injury that initieted events resulting in deeth) Lest Due to (or es a consequence of): Box 68760. Physician/Medical Due to (or es e consequence of): P.O. ate has been signed by the page 2 should be datached Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 20 No 3 Probably 4 Unknown of Vital Records. þ 24b. Were eutopsy findings eveilable prior to complation of cause of daeth? 24e. Wes en eutopsy performed? Completed After this certificate has 1 ☐ Yes 2 ☐ No 1 ☐ Yes XXNo Physician: ours efter death.

•••• Director: After this certifical filled in by the funeral director, 25. Wes case raferred to medical examinar? Be of daughter 26. Place of Death (Check only one) at home Hospital: 1 | Inpatient 2 | ER/Outpetient 3 | DOA Other: 4 Nursing Home 5 Residence White (Specify) Medical Certification: To 1 ☐ Yes XIX No 28e. Date of Injury (Month, Dey Year) 27. Manner of Deeth 28b. Time of Injury 28c. Injury et Work? 28d. Describe how injury occurred or Attanding F Division Natural 5 Pending invastigation 1 Yes 2 No 2 Accident 6 Could not be 281. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 28e. Plece of Injury - At home, ferm, street, fectory, offica building, atc. (Specify) 4 ☐ Homicide To the Mospital of within 24 hours of To the Funeral Completely filled 1 Gertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

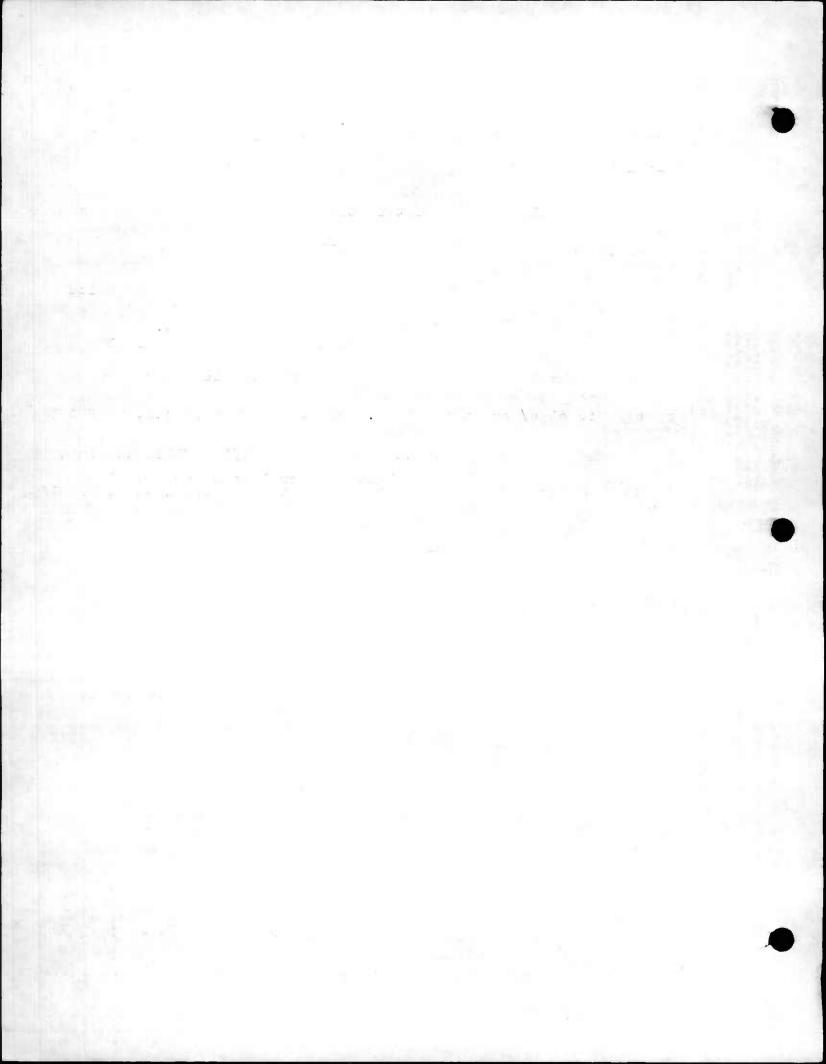
2 Medical Examines: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signeture end title of certifier 1.0033426 July 5, 2000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) B. Larry Jenkins, Jr., P.O. Box 1724, La Plata, MD 20646 31. Date filed (Month, Dey, Year) 32. Registrer's Signetura State 3000 Seperal JUL 06 DOLKS Registrar



State of Maryland / Department of Health and Mental Hygiene 22492 Certificate of Death Reg. No. 1. Decedent's Nema (First, Middle, Last) 2. Date of Death 3. Tima of Death 4:12 p Year **Physician** Angela Rose Ole 9000 /Medical 4a Facility Nama (Whot institution, giva street and number) 4b. City, Town, or Location of Death 4c. County of Death Ctr. Examiner Carroll Lutheran Village Health Care Westminster Carroll If Under 24 Hrs. 8. Dafa of Birth Hours Min. (Month, Day, Year) If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) Birthplaca (Stata or Foreign Country) **Funeral** Days 1 M 283 F Yrs. Director 215-18-9146 Feb 19 1917 Usual Residence of Decedent the Maryland 10a, Stata 10b. County 10c. City, Town or Location 10d. Insida City Limits pernit. Pages 1 and 2 should be filed within 72 hours after deeth with the Manylan Department of Health and Mentel Hyglene. Important: If them 27 is marked other than "natural", or theme 23a or 28a-f show any intry or other traumatte event, the Madool Exempter metter and the model. NO Yes 2 No Director Westminster MD Carroll 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 45 Washington Road 21157 USA Funeral 12. Was Decedent Ever in U,S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, atc.) 14 Race - Amarican Indian Black, White, atc. 1 □ Never Married 2 □ Married 1 ☐ Yas 2 ☐ No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: Specify: White þ 3 □ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grada completed) St. Agnes Elementary/Secondary (0-12) College (1-4or 5+) Pharmacist Hospital 17. Father's Nama (First, Middle, Last) 18. Mother's Nama (First, Middle, Maiden Sumama) B Frances Michaels Patrick Hackett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stata, Zip Coda) Frances Nickolas/Daughter 230 N. Gorsuch Rd Westminster, MD 21157 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Mathod of Disposition 20c. Location - City or Town, Slata 1 ⊠Burial 2 □ Cremetion 3 □ Removal from Stata 4 ☐ Donation 5 ☐ Other (Specify) Lawn Cem Ellicott City, MD Crest 21. Signature of Funaral Service License 22. Nama and Addrass of Facility Pritts Funeral Home and Chapel 412 Washington Rd Westminster, MD 21157 23a. Part Entar the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory errest, shock, or heart failure. List only one cause on each line. Approximala Intervel Between Onset end Death Physician Immediafa Cause (Finel disease or condition resulting in death) /Medical Examiner Due to (or as a consequence of): orosis attending physician and for use as the buriel-trensit Sequentially list conditions, if any, leading to immediata cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Lest Records, P.O. Box 68760. Physician/Medical Due to (or as a consequence of): been signed by the a should be detached t 23b. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Pert I. 1 Yes 2 No 3 Probably 4 Unknown è è 24b. Wera autopsy tindings available prior to completion of cause of death? 24a. Was an autopsy Completed his certificate h 1 Yas 2 No 1 ☐ Yes 2 ☐ No Division of Vital 25. Was casa referred to medical B 26. Place of Death (Check only one) Other: 4 Nursing Homa 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Deta of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: 28b. Tima of After 1 Netural 5 Pending ne Hospital or Attending n 24 hours after death. Ne Funeral Director: After plately filled in by the fun 1 Yes 2 No invastigation 2 Accident 6 Could not be delarmined 3 ☐ Suicide 28f. Location (Street end Number or Rurel Routa Number, City or Town, Stata) 28a. Plece of Injury - At homa, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mannar as stated.

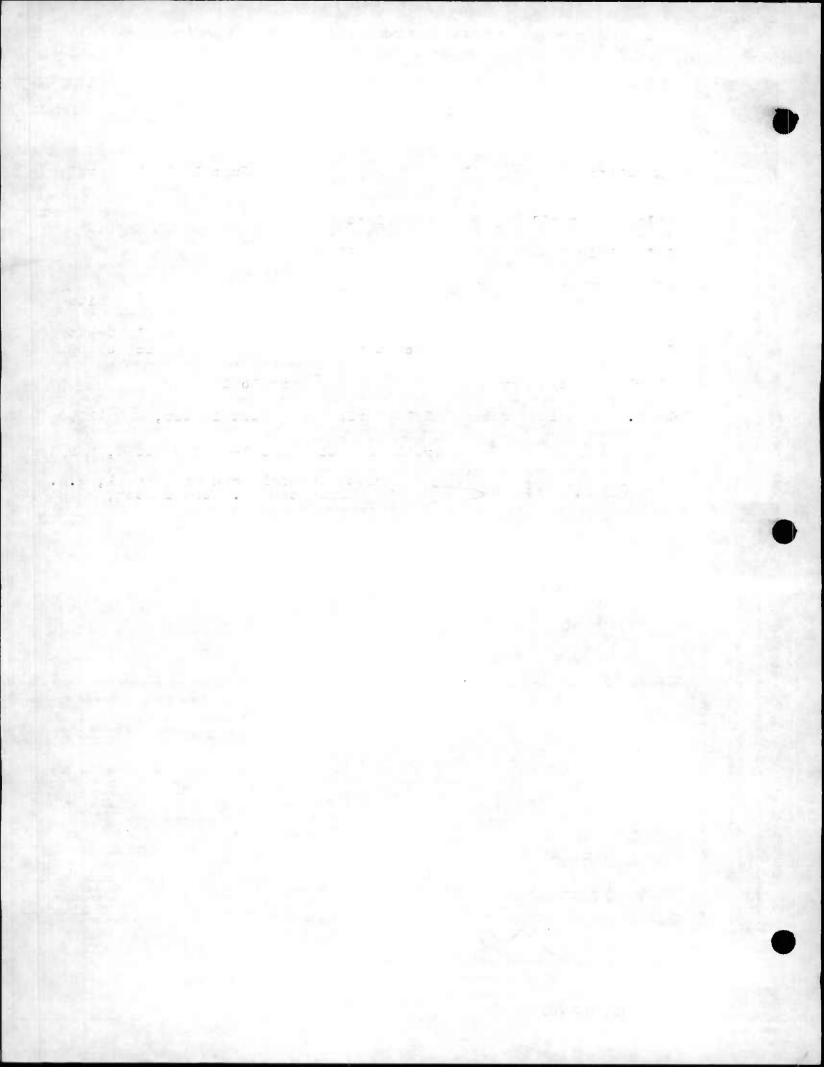
Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie To the Hosp within 24 hor To the Fune completely fi (Check on 29d. Date signed (Month, Day, Year) 29c. License number e and address of persory completed cause of death (Item 23a) (Type, Print) RL Westminister m 0 21157 Kidge 31. Defe filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUN 2 8 2000

DHMH 16 Rev 6/95



State of Maryland / Department of Health and Mental Hygiene 00 22493

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	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Integration: If them 27 is marked other than "natural", or items 23a or 28a-f show many Injury or other traumatic event, tra Medical Examinar mast be notified any Injury or other traumatic event, tra Medical Examinar mast be notified and the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the second of the se	10e. Street and Number 1510 Chris I	ane				ip Coda 1158	3			USA	What Cour	ntry?
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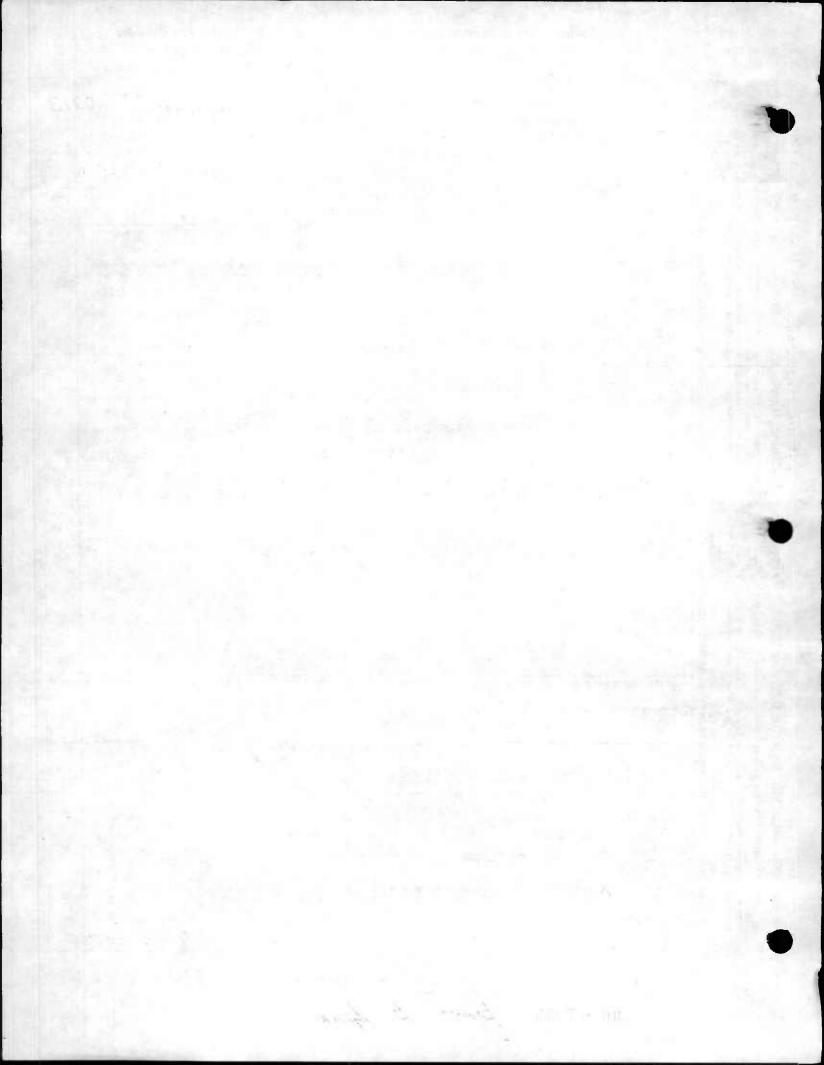
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

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State Registrar

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Neme (First, Middle, Last) 2. Dete of Deeth 3. Time of Deeth Reba Ellen 5, July Butler 2000 3:35 AM 4a. Fecility Neme (If not institution, giva street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth 33338 West Office Road Princess Anne Somerset If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Sociel Security Number 7. Aga (In yrs. lest birthday) 8. Date of Birth (Month, Dey, Year) Birthpleca (Steta or Foreign Country) Days 215-26-4476 68 08/21/1931 Maryland Usuel Residence of Decedent 10e. Stete 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Somerset Maryland Princess Anne 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 33338 West Post Office Road 21853 USA 12. Was Decedent Evar In U,S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify Specify 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Dispatcher Oil Company 17. Fether's Neme (First, Middle, Last) 18. Mother's Nama (First, Middle, Maidan Surnama) Elton Dykes Evelyn Dryden 19a. Informent's Neme/Relationship (Type, Print) 19b. Meiling Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) 21853 Diane Ballard/Daughter 33338 West Post Office Road, Princess Anne, Md. 20b. Place of Disposition (Name of cemetery, cremetory or other piece) 20e. Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Cremation 3 Removel from State 4 ☐ Donation 5 ☐ Other (Specify) Perryhawkin Christian Cem. 7/8/00 Princess Anne, Md. Signature of Funeral Se 22. Name end Address of Fecility Hinman Funeral Home UNCOL MODE 295 11673 Somerset Ave., Princess Anne, Md. 21853 23s. Pert1. Enter the disease, or complications that ceused the deeth. Do not enter the mode of dying, such as cerdiec or respiratory arrest, shock, or heart failure. List only one ceuse on each line. Netatatic (cone Due to (or es e consequence of Due to (or es e consequence of) Due to (or es e consequence of) 23b. Did tobacco uea contribute to the cause of death? Yes 2□ No 3 Probably 4 Unknown 24b. Were autopsy findings eveileble prior to completion of cause of deeth? 24a. Wes an eutopsy performed? 1 🗌 Yes

Physician /Medical Examiner

8

The law requires that the death certificate

Physician

/Medical

Examiner

Funeral

Director

than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at

Director

Funeral

Completed

Be

the Maryland

filed within 72 hours after

Hygiene.

permit. Pages 1 and 2 should be logariment of Health and Mental Important: If Hem 27 is marked of any Injury or other traumatic eve

Baltimore, Maryland 21215-0020

Physician/Medical Examiner Completed Be 2 Certification:

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attending (for use as has or Attending Physician: after death. Director: After this certifica To the Hospital or A within 24 hours after To the Funeral Direction plants filled in b

Division of Vital Records, P.O. Box 68760

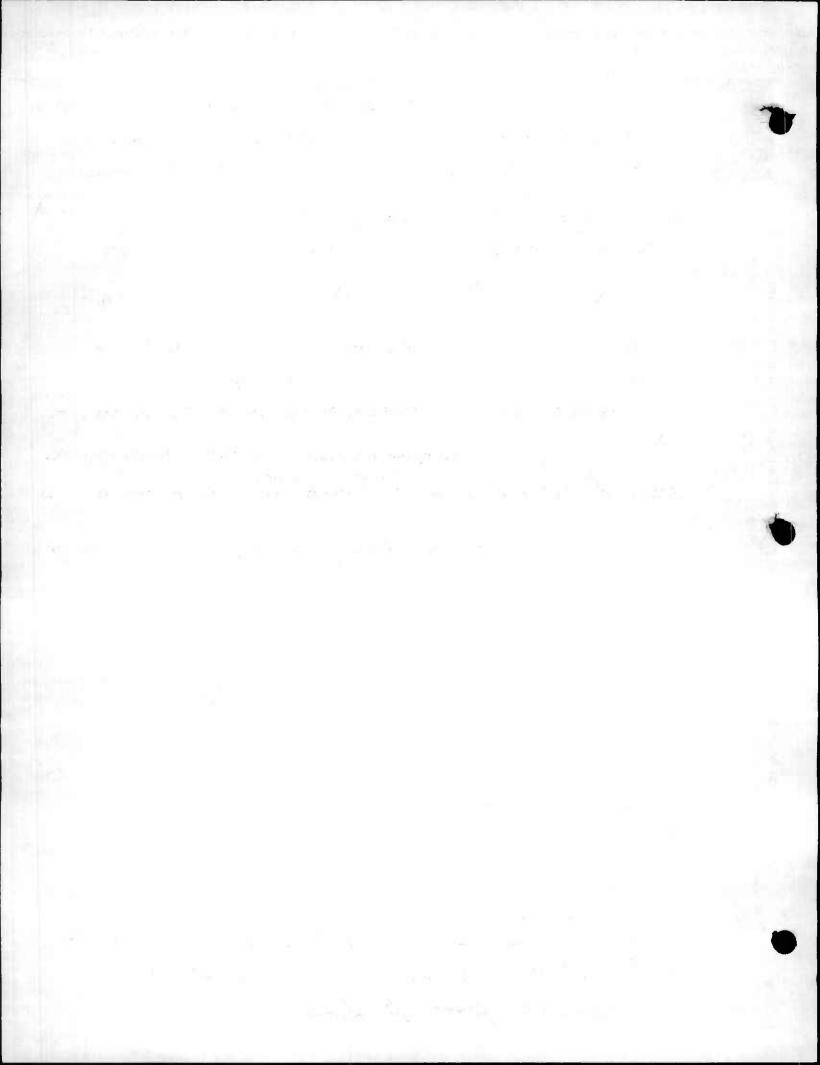
State Registrar

Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Pert II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpetlent 3 DOA 28a. Date of Injury (Month, Day Year) 27. Magner of Death 28c. Injury et Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Plece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street end Number or Rurel Route Number, City or Town, Stete) 4 Homicide ### Certifying Phyelcien: To the best of my knowledge, deeth occurred et the time, dete end plece, end due to the ceuse(s) end menner es steted.

| Madicel Examiner: On the basis of examination end/or investigation, in my opinion, deeth occurred at the time, dete end place, end due to the ceuse(s) end menner steted. 29a. Certifier Medical (Check only one) 296. Signature and title of certif 29c. License number 29d. Date signed (Month, Dey, Yeer)

MO weal) 145E (0 vv0/1 31. Data filed (Month, Day, Yeer) 32. Registrer's Signature

30. Name end address of person who completed cause of deeth (Item 23a) (Type, Print)



Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 22496

					Ce	milical	e or	Death			Reg. No.		
	1. Decedent's Name (First, M	liddla, Las	it)	WE DO			130			2. Date of De	ath	V	3. Time of Dea
hysician	Marguerite		Col	e						June	30.	2000	8:10 AM
/Medical Examiner	4a Facility Name (If not instit	ution, give	street end nu	mber)				4b. City, To	wn, or Lo	cation of Deat			
.xummer	·Chesapeake Ho	spice	House					Linth	nicum		Anne	Arund	el
uneral	5. Social Security Number	6. Se	ех	7. Age (In yrs	. last birthday,		1 Yeer	If Under		8. Date of Bir	th W Year)	9. Birth	place (State or For
rector	022-26-2938	11	□M 2√F	78	Yrs.	Months	Days	Hours	Min.	8. Date of Bir Month Da April	7, I922	Mar	yland
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or 2	10e. Street and Number					10f. Zip	Code				10g. Citizen of	What Cou	intry?
238	1703 Tarrytov	vn Ave	nue				21114				USA		
item 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Examiner must be notified at other traumatic event, the Medical Events of Section 1 is a second of the Completed by Funeral Director	11. Marital Status	301	Armed Fo	edent Ever in I	U,S. 13.	Was Dece	dent of h	fispanic Ori	gin? (Spe	cify Yes or No	- 14. Ra	ce - Ameri	ican Indien,
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= E	19a. Informant's Name/Ratat				19b. Mall	ing Address	(Street	and Numbe	er or Rura	I Route Numb	er, City or Town	n, State, Zi	ip Code)
other tr	Lanier G. Cole	e/ Hus	band	1000	1703	Tarry	town .	Avenue	Crof	ton, Mar	yland 211	114	
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State of Maryland / Department of Health and Mental Hygiene 0 221,97

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ч	Examir	ner	4a. Facility Name (If not institution, g						137		ocation of Deeth		10,000		
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21215-0020	ges 1 end 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If Item 27 Is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Evanines must be notified at	by Funeral Director	11. Maritei Status 1 □ Nevar Merried 2 □ Married 3 □ Widowed 4 □ Divorced	12. Wes Decedar Armed Forces 1 Yas 2X if Yes, Give Yaer or Dates	? M No	'	Was Deced If Yes, spec 1 ☐ Yes	cify Cub	en, Mexicer	gin? (Sp , Puerto	pecify Yas or No Ricen, etc.)		ck, White,	cen Indien, etc. ite	
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	e dea he att	Physician/	Part ti. Other significant conditions	contributing to death	but not resulting	In the u	nderlying o	euse gi	ven in Pert I		23b. Dld	tobacco use c	ontribute t	o the cause	of death?
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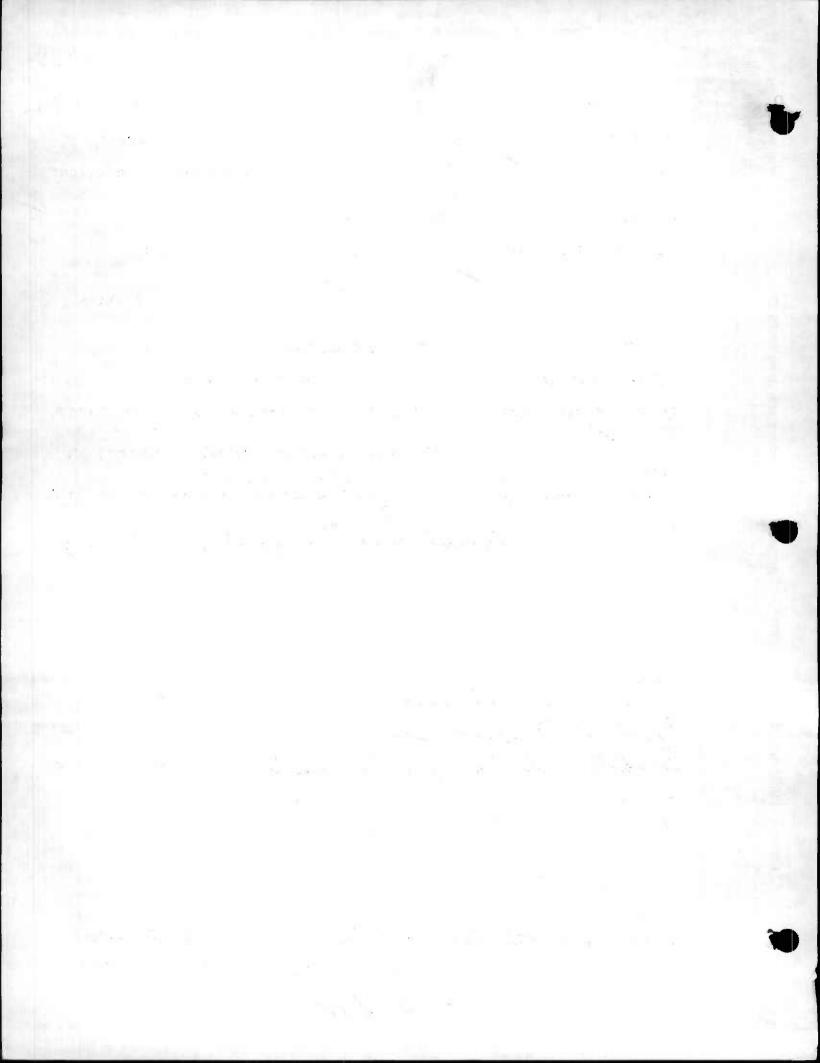
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State of Maryland / Department of Health and Mental Hygiene 22499 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Dete of Death 3. Time of Deeth 715 AM Month **Physician** ADA COX 03 2000 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Manokin Manor Nursing Home Princess Somerset Anne if Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Dey, Yeer) 5. Sociel Security Number 7. Age (In yrs. lest birthday) **Funeral** Birthplece (State or Foreign Country) 1 M 20 F Months Director 219-07-3868 82 3 12 03-22-1918 Maryland Usuel Residence of Decedent 10e. State 10b. County 10c. City, Town or Location 10d. Inside City Limits notified at Director 1 Yes 2 No 28a-f Maryland Somerset Princess Anne 10e. Street end Number 10f. Zlp Code 10g. Citizen of What Country? ò "natural", or items 23a or idical Examiner must be 11974 Edgehill Terrace 21853 Completed by Funeral U.S. 12. Was Decedent Ever in U,S Armed Forces? 13. Was Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indien, Biack, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: filed within 72 hours after 1 ☐ Neyer Married 2 ☐ Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No Specify: 3 Widowed 4 □ Divorced Specify. White adical 16a. Decedent's Usuei Occupetion (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry the Me Eiementery/Secondary (0-12) Coilege (1-4or 5+) 9 Grocery Store Owner Food Service 17. Fether's Neme (First, Middle, Last) permit. Pepes 1 and 2 should be file.
Department of Health and Mental Hy
Important: If Nem 27 is marked oth
any injury or other traumatic event 18. Mother's Name (First, Middle, Malden Sumeme) Be James Horner Almira Insley 19a. Informent's Name/Relationship (Type, Print) 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, Stete, Zip Code) Cynthia Elza/Daughter P.O. Box 202, Princess Anne, Md. 21853 20b. Plece of Disposition (Neme of cemetery, cremetory or other plece) 20e. Method of Disposition 20c. Location - City or Town, State 1 ☐ Buriei 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donetion 5 ☐ Other (Specify) Salisbury Crematory 7/11/00 Salisbury, Md. 21. Signature of Funerei Service Licensee 22. Neme and Address of Fecility Hinman Funeral Home, P.A. 11673 Somerset Ave, Princess Anne, Md. 21853
Approximate the mode of dying, such as cardiac or respiretory errest,
Approximate the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of the role of M00295 23a. In Enter the disease, or complications that caused the death. Do not hook, or heart feiture. List only one cause on each line. **Physician** Immediate Cause (Final disease or condition resulting in death) /Medical Examiner Due to (or es e consequence of): The law requires that the death certificate be executed attending physician and for use as the buriel-transit Physician/Medicai Exami Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or es e consequence of): Box 68760. thet initieted events resulting in death) Lest Due to (or es e consequence of) P.O. Pert It. Other elgnificant conditions contributing to death but not resulting in the underlying cause given in Part i. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown signed l Records, þ 24b. Were autopsy findings aveileble prior to completion of cause of death? page 2 should Completed 24a. Wes en eutopsy 1 Yes 2 No 1 Yes 2 No of Vital director Be 25. Was case referred to medical 26. Piece of Deeth (Check only one) Other: 4 Marsing Home 5 Residence 6 Other (Specify) ၉ 1 Yes 2 No 1 ☐ inpatient 2 ☐ ER/Outpetient 3 ☐ DOA To the Hospital or Attending Phys within 24 hours effer death.

To the Funeral Director: Affer this of completely filled in by the funeral directors. this 27. Manner of Deeth 28e. Dete of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: Division 1 Naturai 5 Pending Investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Piece of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rure! Route Number, City or Town, Stete) 4 Homicide edical 1 Certifying Phyelcian: To the best of my knowledge, deeth occurred et the time, dete end piace, end due to the ceuse(s) end menner es steted.

2 Medical Examiner: On the best of examination and/or investigetion, in my opinion, death occurred et the time, date end piece, and due to the cause(s) end menner stated. 29a, Certifier 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dey, Year) com 30. Name and address of person who completed cause of deeth (item 23e) (Type, Print) GREGORIO M. BELLOSO, M.D. : 5302 CHINABERRY DR., SALISBURY, MD Z1801 31. Dete filed (Month, Dey, Year) 32. Registrer's Signeture State Registrar JUL 0 5 2000

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Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. Amend #5,6/23/2000, BMW, Montg. Co.

State of Maryland / Department of Health and Mental Hygiene
Amended #23b, 6/16/2000, Per MD, JW, Mont Co. Certificate of Death 1. Decedent's Neme (First, Middle, Lest) 2. Dete of Deeth Month D6 **Physician** Imer 5:20pm 2000 /Medical 4e. Fecility Neme (If not institution, give street end number) 4b. City, Town, or Location of Deeth 4c. County of Deeth **Examiner** Bethesda 6530 Montgomery If Under 24 Hrs. 8. Date of Birth (Month, Dey, 7. Age (In yrs. lest birthday) If Under 1 Year 6. Sex 8. Date of Birth (Month, Dey, Yeer)
January 18, 1914 Guilford, Ct. Funeral 1₺ M 2□ F Months Deys Hours **Director** 86 Usual Residence of Decadent the Maryland 10e. State 10b. County 10c. City, Town or Location them 27 is marked other than "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinar must be notified at 10d. Inside City Limits Director Ct. to Yes 2 □ No New Haven Guilford 10e. Street and Number 10f. Zip Code 10g. Citizen of Whet Country? death with 71 High Meadow Road 06437 U.S.A. Funeral 12. Wes Decedent Ever In U,S. Armed Forces? Wes Decedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.) 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours effer of Department of Health and Mental Hygiene. Important if them 27 is merked other than "natural", or then any injury or other traumatic event. Bleck, White, etc. 1 XYes 2 No 942 If Yes, Give 1945 Yeer or Dates: 1945 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0020 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decadent's Education (Specify only highest grede completed) 16a. Decedent's Usuel Occupetion (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Business Man Self-Employed 17. Fether's Neme (First, Middle, Last) 18. Mother's Neme (First, Middle, Melden Sumeme) Be Palmer Smith Chambers 2 Anna Parsons 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Stete, Zip Code) Britta Chambers/Wife P.O. Box 123 Guilford Connecticut, 06437 20b. Plece of Disposition (Neme of cemetery, crematory or other place) 20a. Method of Disposition June 11. 20c. Location - City or Town, Stete 1 ☐ Buriel 2 ☐ Cremetion 3 ☐ Removel from State 4 ☐ Donetion 5 ☐ Other (Specify) Metropolitan Crematory 2000 Alexandria, Virginia 22. Name end Address of Fecility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Wash. D.C. 20007 Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiretory errest, or heart feilure. List only one ceuse on each line. Approximete Intervel Between Onset and Deeth Physician /Medical Immediete Ceuse (Finel diseese or condition resulting in death) Examiner Examiner Pneumonia To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the humat-transit Sequentially list conditions, if eny, leeding to Immediate cause. Enter Underlying Ceuse (Disease or Injury that initiated events resulting in death) Lest Due to (or es e consequença of): P.O. Box 68760, Physician/Medical Due to (or es e consequenca of): Pert tt. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 ☐ Unknown Records, Completed by 24b. Were autopsy findings evelleble prior to completion of cause of deeth? 24e. Wes en eutopsy performed? 1 Yes 2 No 1 TYes 2 No Division of Vital Be 25. Was case referred to medical exeminer? 26. Piece of Deeth (Check only one) 1 Yes 2 No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpetient 3 ☐ DOA Certification: To Other: 4 Nursing Home 5 Residence 6 Other (Specify) 28e. Dete of Injury (Month, Day Year) 27. Menner of Deeth 28c. Injury et Work? 28d. Describe how Injury occurred 28b. Time of 5 Pending investigation 1 Neturel 2□ Accident 1 Yes 2 No 6 Could not be 3 Suicide 28e. Pleca of Injury - At home, ferm, street, fectory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, Stete) 4 Homicide 1 Certifying Physician: To the best of my knowledge, deeth occurred et the time, date end plece, end due to the ceuse(s) end menner es steted.
2 Medical Examiner: On the best of examinetion end/or investigetion, in my opinion, deeth occurred et the time, date end placa, and due to the cause(s) end menner steted. Medical 29a. Certifier (Check only one) 29b. Signeture end title of certifier 29c. License number 29d. Date signed (Month, Dey, Year) 30. Name and eddress of person who completed cause of deeth (Item 200) (Type, Print)

9801

32. Registrer's Signeture

RGIA AVE, SILVER

State Registrar

31. Dete filed (Month, Dey, Year)

JUN 1 6 2000

